Title 284 WAC

INSURANCE COMMISSIONER, OFFICE OF

Chapters

Chapter 284-02 WAC

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

WAC

WAC 284-02-070 How does the OIC conduct hearings? (1) **Generally.**

(a) Hearings of the OIC are conducted according to chapter 48.04 RCW and the Administrative Procedure Act (chapter 34.05 RCW). In addition to general hearings conducted pursuant to RCW 48.04.010, two specific types of hearings are conducted pursuant to the Administrative Procedure Act: Rule-making hearings and adjudicative proceedings or contested case hearings. Contested case hearings include appeals from disciplinary actions taken by the commissioner.

(b) **How to demand or request a hearing.** 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 the failure is deemed an act under the insurance code or the Administrative Procedure Act.

(i) Hearings can be demanded by an aggrieved person based on any report, promulgation, or order of the commissioner.

(ii) Requests for hearings must be in writing and delivered to the Tumwater office of the OIC. The request must specify how the person making the demand has been aggrieved by the commissioner, and must specify the grounds to be relied upon as the basis for the relief sought.

(c) Accommodation will be made for persons needing assistance, for example, where English is not their primary language, or for hearing impaired persons.

(2) **Proceedings for contested cases or adjudicative hearings.**

(a) Provisions specifically relating to disciplinary action taken against persons or entities authorized by the OIC to transact the business of insurance are contained in RCW 48.17.530, 48.17.540, 48.17.550, 48.17.560, chapter 48.102 RCW, and other chapters related to specific licenses. Provisions applicable to other adjudicative proceedings are contained in chapter 48.04 RCW and the Administrative Procedure Act (chapter 34.05 RCW). The uniform rules of practice and procedure appear in Title 10 of the Washington Administrative Code. The grounds for disciplinary action against insurance agents, brokers, solicitors, and adjusters are contained in RCW 48.17.530; grounds for similar action against insurance companies are contained in RCW 48.05.140; grounds for actions against fraternal benefit societies are found at RCW 48.36A.300 (domestic) and RCW 48.36A.310 (foreign); grounds for actions against viatical settlement providers are found in chapter 48.102 RCW; grounds for actions against health care service contractors are contained in RCW 48.44.160; and grounds for action against health maintenance organizations are contained in RCW 48.46.130. Grounds for actions against other persons or entities authorized by the OIC under Title 48 RCW are found in the chapters of Title 48 RCW applicable to those licenses.

(b) The insurance commissioner may suspend or revoke any license, certificate of authority, or registration issued by the OIC. In addition, the commissioner may generally levy fines against any persons or organizations having been authorized by the OIC.

(c) Adjudicative proceedings or contested case hearings of the insurance commissioner are informal in nature, and compliance with the formal rules of pleading and evidence is not required.

(i) The insurance commissioner may delegate the authority to hear and determine the matter and enter the final order under RCW 48.02.100 and 34.05.461 to a presiding officer; or may use the services of an administrative law judge in accordance with chapter 34.12 RCW and the Administrative Procedure Act (chapter 34.05 RCW). The initial order of an administrative law judge will not become a final order without the commissioner's review (RCW 34.05.464).

(ii) The hearing will be recorded by any method chosen by the presiding officer. Except as required by law, the OIC

is not required, at its expense, to prepare a transcript. Any party, at the party's expense, may cause a reporter approved by the presiding officer to prepare a transcript from the agency's record, or cause additional recordings to be made during the hearing if, in the opinion of the presiding officer, the making of the additional recording does not cause distraction or disruption. If appeal from the insurance commissioner's order is made to the superior court, the recording of the hearing will be transcribed and certified to the court.

(iii) The insurance commissioner or the presiding officer may allow any person affected by the hearing to be present during the giving of all testimony and will allow the aggrieved person a reasonable opportunity to inspect all documentary evidence, to examine witnesses, and to present evidence. Any person heard must make full disclosure of the facts pertinent to the inquiry.

(iv) Unless a person aggrieved by an order of the insurance commissioner demands a hearing within ninety days after receiving notice of that order, or in the case of persons or entities authorized by the OIC to transact the business of insurance under Title 48 RCW, within ninety days after the order was mailed to the most recent address shown in the OIC's licensing records, the right to a hearing is conclusively deemed to have been waived (RCW 48.04.010(3)).

(v) Prehearing or other conferences for settlement or simplification of issues may be held at the discretion and direction of the presiding officer.

(d) Discovery is available in adjudicative proceedings and contested cases pursuant to Civil Rules 26 through 37 as now or hereafter amended without first obtaining the permission of the presiding officer or the administrative law judge in accordance with RCW 34.05.446(2).

(i) Civil Rules 26 through 37 are adopted and incorporated by reference in this section, with the exception of CR 26 (j) and (3) and CR 35, which are not adopted for purposes of this section.

(ii) The presiding officer or administrative law judge is authorized to make any order that a court could make under CR 37 (a) through (e), including an order awarding expenses of the motion to compel discovery or dismissal of the action.

(iii) This rule does not limit the presiding officer's or administrative law judge's discretion and authority to condition or limit discovery as set forth in RCW 34.05.446(3).

(3) **Rule-making hearings.** Rule-making hearings are conducted based on requirements found in the Administrative Procedure Act (chapter 34.05 RCW) and chapter 34.08 RCW (the State Register Act).

(a) Under applicable law all interested parties must be provided an opportunity to express their views concerning a proposed rule, either orally or in writing. The OIC will accept comments on proposed rules by mail, electronic telefacsimile transmission, or electronic mail but will not accept comments by recorded telephonic communication or voice mail (RCW 34.05.325(3)).

(b) Notice of intention of the insurance commissioner to adopt a proposed rule or amend an existing rule is published in the state register and is sent to anyone who has requested notice in advance and to persons who the OIC determines would be particularly interested in the proceeding. Persons requesting paper copies of all proposed rule-making notices of inquiry and hearing notices may be required to pay the cost of mailing these notices (RCW 34.05.320(3)).

(c) Copies of proposed new rules and amendments to existing rules as well as information related to how the public may file comments are available on the OIC web site (www.insurance.wa.gov).

[Statutory Authority: RCW 48.02.060 and 34.05.446(2). 09-19-001 (Matter No. R 2008-24), § 284-02-070, filed 9/2/09, effective 10/3/09. Statutory Authority: RCW 48.02.060 and 34.05.220. 08-14-170 (Matter No. R 2008-10), § 284-02-070, filed 7/2/08, effective 8/2/08; 07-01-048 (Matter No. R 2003-09), § 284-02-070, filed 12/14/06, effective 1/14/07. Statutory Authority: RCW 48.02.060 and 34.05.220 (1)(b). 96-09-038 (Matter No. R 96-3), § 284-02-070, filed 4/10/96, effective 5/11/96. Statutory Authority: RCW 48.02.060 (3)(a). 91-17-013 (Order R 91-5), § 284-02-070, filed 8/13/91, effective 9/13/91; 88-23-079 (Order R 88-10), § 284-02-070, filed 11/18/88; Order R-68-6, § 284-02-070, filed 8/23/68, effective 9/23/68.]

Chapter 284-07 WAC

REQUIREMENTS AS TO COMPANY REPORTS AND ANNUAL STATEMENTS

WAC

WAC 284-07-100 Purpose and scope. (1) The purpose of WAC 284-07-100 through 284-07-230 is to improve the Washington state insurance commissioner's surveillance of the financial condition of insurers by requiring:

(a) An annual audit of financial statements reporting the financial position and the results of operations of insurers by independent certified public accountants;

(b) *Communications of Internal Control Related Matters Noted in an Audit*; and

(c) Management's report of internal control over financial reporting.

(2) Every insurer, as defined in WAC 284-07-110, shall be subject to WAC 284-07-100 through 284-07-230. Insurers having direct premiums written of less than one million dollars in any calendar year and less than one thousand policyholders or certificate holders of direct written policies nation-

wide at the end of the calendar year shall be exempt from WAC 284-07-100 through 284-07-230 for the year (unless the commissioner makes a specific finding that compliance is necessary for the commissioner to carry out statutory responsibilities) except that insurers having assumed premiums pursuant to contracts and/or treaties of reinsurance of one million dollars or more will not be so exempt.

(3) Foreign or alien insurers filing the audited financial report in another state, pursuant to that state's requirement for filing of audited financial reports, which has been found by the commissioner to be substantially similar to the requirements herein, are exempt from WAC 284-07-120 through 284-07-210 if:

(a) A copy of the audited financial report, *Communication of Internal Control Related Matters Noted in an Audit*, and the Accountants' Letter of Qualifications that are filed with the other state are filed with the NAIC in accordance with the filing dates specified in WAC 284-07-120, 284-07-190 and 284-07-200, respectively (Canadian insurers may submit accountant's reports as filed with the Office of the Superintendent of Financial Institutions, Canada); and

(b) A copy of any Notification of Adverse Financial Condition Report filed with the other state is filed with the NAIC within the time specified in WAC 284-07-180.

(4) Foreign or alien insurers required to file management's report of internal control over financial reporting in another state are exempt from filing the report in this state provided the other state has substantially similar reporting requirements and the report is filed with the commissioner of the other state within the time specified.

(5) WAC 284-07-100 through 284-07-230 shall not prohibit, preclude, or in any way limit the commissioner from ordering, conducting, or performing examinations of insurers under the rules, regulations, practices, and procedures of the insurance commissioner.

(6) All reports and filings required by WAC 284-07-100 through 284-07-230 must be filed electronically with the commissioner. Insurers must electronically transmit the report or filing in PDF or other format as noted on the commissioner's web site. The commissioner has the discretion to allow an insurer to file paper copies of reports and filings required by WAC 284-07-100 through 284-07-230. The insurer must demonstrate that filing in electronic form will create an undue financial hardship for the insurer. Applications for permission to file in hard copy must be received by the commissioner at least ninety days before the statement of annual statement is due.

(7) To comply with statutory or other requirements that reports or filings be signed or verified, insurers and accountants may:

(a) Use a method of electronic signature verification that has been approved by the commissioner; or

(b) File a paper copy of the signature or verification at the time of the electronic transmission of the report or filing.

(8) The report or filing and the appropriate signatures and/or verifications must both be received to complete a filing. The date of receipt of the later of the two parts of the filing is considered the receipt date of the report or filing.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.05.250, 48.44.095, 48.46.080, 48.46.200, and 48.125.090. 09-20-069 (Matter No. R 2009-09), § 284-07-100, filed 10/5/09, effective 11/5/09. Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 06-16-093 (Matter No. R 2006-06), § 284-07-100, filed 7/31/06, effective 8/31/06; 02-21-120 (Matter No. R 2002-07), § 284-07-100, filed 10/23/02, effective 11/23/02. Statutory Authority: RCW 48.02.060, 48.43.140, 48.44.050 and 48.46.200. 94-04-045 (Order R 94-2), § 284-07-100, filed 1/27/94, effective 2/27/94. Statutory Authority: RCW 48.02.060. 92-19-040 (Order R 92-10), § 284-07-100, filed 9/9/92, effective 10/10/92.]

WAC 284-07-110 Definitions. For the purposes of WAC 284-07-100 through 284-07-230 the following definitions shall apply:

(1) "Accountant" or "independent certified public accountant" means an independent certified public accountant or accounting firm in good standing with the American Institute of Certified Public Accountants (AICPA) and in all states in which he or she is licensed to practice; for Canadian and British companies, the terms mean a Canadian-chartered or British-chartered accountant.

(2) An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

(3) "Audit committee" means a committee (or equivalent body) established by the board of directors of an entity for the purpose of overseeing the accounting and financial reporting processes of an insurer or group of insurers, and audits of financial statements of the insurer or group of insurers. The audit committee of any entity that controls a group of insurers may be deemed to be the audit committee for one or more of these controlled insurers solely for the purposes of WAC 284-07-100 through 284-07-230 at the election of the controlling person. Refer to WAC 284-07-213(5) for exercising this election. If an audit committee is not designated by the insurer, the insurer's entire board of directors shall constitute the audit committee.

(4) "Audited financial report" means and includes those items specified in WAC 284-07-130.

(5) "Group of insurers" means those licensed insurers included in the reporting requirements of chapters 48.31B and 48.31C RCW, or a set of insurers as identified by management, for the purpose of assessing the effectiveness of internal control over financial reporting.

(6) "Indemnification" means an agreement of indemnity or a release from liability where the intent or effect is to shift or limit in any manner the potential liability of the person or firm for failure to adhere to applicable auditing or professional standards, whether or not resulting in part from knowing of other misrepresentations made by the insurer or its representatives.

(7) "Independent board member" has the same meaning as described in WAC 284-07-213(3).

(8) "Insurer" has the same meaning as set forth in RCW 48.01.050. It also includes health care service contractors registered under chapter 48.44 RCW, health maintenance organizations registered under chapter 48.46 RCW, fraternal benefit societies registered under chapter 48.36A RCW, and self-funded multiple employer welfare arrangements authorized under chapter 48.125 RCW.

(9) "Internal control over financial reporting" means a process effected by an entity's board of directors, management and other personnel designed to provide reasonable assurance regarding the reliability of the financial statements,

i.e., those items specified in WAC 284-07-130 (2)(b) through (g) and includes those policies and procedures that:

(a) Pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of assets;

(b) Provide reasonable assurance that transactions are recorded as necessary to permit preparation of the financial statements, i.e., those items specified in WAC 284-07-130 (2)(b) through (g) and that receipts and expenditures are being made only in accordance with authorizations of management and directors; and

(c) Provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of assets that could have a material effect on the financial statements, i.e., those items specified in WAC 284-07-130 (2)(b) through (g).

(10) "NAIC" means the National Association of Insurance Commissioners.

(11) "Policy holder" shall also mean subscriber.

(12) "SEC" means the United States Securities and Exchange Commission.

(13) "Section 404" means Section 404 of the Sarbanes-Oxley Act of 2002 and the SEC's rules and regulations promulgated thereunder.

(14) "Section 404 report" means management's report on internal control over financial reporting as defined by the SEC and the related attestation report of the independent certified public accountant described in WAC 284-07-110(1).

(15) "SOX compliant entity" means an entity that either is required to be compliant with, or voluntarily is compliant with, all of the following provisions of the Sarbanes-Oxley Act of 2002:

(a) The preapproval requirements of Section 201 (Section 10A(i) of the Securities and Exchange Act of 1934);

(b) The audit committee independence requirements of Section 301 (Section 10A (m)(3) of the Securities and Exchange Act of 1934); and

(c) The internal control of financial reporting requirements of Section 404 (Item 308 of SEC Regulations S-K).

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.05.250, 48.44.095, 48.46.080, 48.46.200, and 48.125.090. 09-20-069 (Matter No. R 2009-09), § 284-07-110, filed 10/5/09, effective 11/5/09. Statutory Authority: RCW 48.02.060, 48.05.250, 48.44.050, 48.44.095, 48.46.080, 48.46.-200, and 48.125.090. 09-07-044 (Matter No. R 2008-29), § 284-07-110, filed 3/11/09, effective 4/11/09. Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 02-21-120 (Matter No. R 2002-07), § 284-07-110, filed 10/23/02, effective 11/23/02. Statutory Authority: RCW 48.02.060, 48.43.-140, 48.44.050 and 48.46.200. 94-04-045 (Order R 94-2), § 284-07-110, filed 1/27/94, effective 2/27/94. Statutory Authority: RCW 48.02.060. 92-19-040 (Order R 92-10), § 284-07-110, filed 9/9/92, effective 10/10/92.]

WAC 284-07-120 General requirements related to filing and extensions for filing of annual audited financial reports and audit committee appointment. (1) All insurers shall have an annual audit by an independent certified public accountant and shall file an audited financial report with the commissioner on or before June 1 for the year ended December 31 immediately preceding. The commissioner may require an insurer to file an audited financial report earlier than June 1 with ninety days advance notice to the insurer.

(2) Extensions of the June 1 filing date may be granted by the commissioner for thirty-day periods upon a showing by the insurer and its independent certified public accountant of the reasons for requesting an extension and determination by the commissioner of good cause for an extension. The request for extension must be submitted in writing not less than ten days prior to the due date in sufficient detail to permit the commissioner to make an informed decision with respect to the requested extension.

(3) If an extension is granted in accordance with the provisions in subsection (2) of this section, a similar extension of thirty days is granted to the filing of management's report of internal control over financial reporting.

(4) Every insurer required to file an annual audited financial report pursuant to WAC 284-07-100 through 284-07-230 shall designate a group of individuals as constituting its audit committee, as defined in WAC 284-07-110(3). The audit committee of an entity that controls an insurer may be deemed to be the insurer's audit committee for purposes of WAC 284-07-100 through 284-07-230 at the election of the controlling person.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.05.250, 48.44.095, 48.46.080, 48.46.200, and 48.125.090. 09-20-069 (Matter No. R 2009-09), § 284-07-120, filed 10/5/09, effective 11/5/09. Statutory Authority: RCW 48.02.060. 92-19-040 (Order R 92-10), § 284-07-120, filed 9/9/92, effective 10/10/92.]

WAC 284-07-130 Contents of annual audited financial report. (1) The annual audited financial report shall report the financial position of the insurer as of the end of the most recent calendar year and the results of its operations, cash flows, and changes in capital and surplus for the year then ended in conformity with statutory accounting practices prescribed, or otherwise permitted, by the commissioner of the state of domicile.

(2) The annual audited financial report shall include the following:

(a) Report of independent certified public accountant.

(b) Balance sheet reporting admitted assets, liabilities, capital, and surplus.

(c) Statement of operations.

(d) Statement of cash flows.

(e) Statement of changes in capital and surplus.

(f) Notes to financial statements. These notes shall be those required by the appropriate NAIC Annual Statement Instructions and *NAIC Accounting Practices and Procedures Manual*. The notes shall include a reconciliation of differences, if any, between the audited statutory financial statements and the annual statement filed pursuant to RCW 48.05.250, 48.05.073, 48.36A.260, 48.43.050, 48.43.097, 48.44.095, 48.46.080, or 48.125.090 with a written description of the nature of these differences.

(g) The financial statements included in the audited financial report shall be prepared in a form and using language and groupings substantially the same as the relevant sections of the annual statement of the insurer filed with the commissioner, and the financial statement shall be comparative, presenting the amounts as of December 31 of the current year and the amounts as of the immediately preceding December 31. However, in the first year in which an insurer is required to file an audited financial report, the comparative data may be omitted.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.05.250, 48.44.095, 48.46.080, 48.46.200, and 48.125.090. 09-20-069 (Matter No. R 2009-09), § 284-07-130, filed 10/5/09, effective 11/5/09. Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 02-21-120 (Matter No. R 2002-07), § 284-07-130, filed 10/23/02, effective 11/23/02. Statutory Authority: RCW 48.02.060, 48.05.073, 48.43.097, 48.44.050, 48.46.200. 01-21-075 (Matter No. R 2001-03), § 284-07-130, filed 10/18/01, effective 11/18/01. Statutory Authority: RCW 48.02.060, 48.43.140, 48.44.050 and 48.46.200. 94-04-045 (Order R 94-2), § 284-07-130, filed 1/27/94, effective 2/27/94. Statutory Authority: RCW 48.02.060. 92-19-040 (Order R 92-10), § 284-07-130, filed 9/9/92, effective 10/10/92.]

WAC 284-07-140 Designation of independent certified public accountant. (1) Each insurer required by WAC 284-07-100 through 284-07-230 to file an annual audited financial report must, within sixty days after becoming subject to the requirement, register with the commissioner in writing the name and address of the independent certified public accountant or accounting firm retained to conduct the annual audit set forth in WAC 284-07-100 through 284-07-230. Insurers not retaining an independent certified public accountant on the effective date of WAC 284-07-100 through 284-07-230 shall register the name and address of their retained independent certified public accountant not less than six months before the date when the first audited financial report is to be filed.

(2) The insurer shall obtain a letter from the accountant, and file a copy with the commissioner stating that the accountant is aware of the provisions of the Washington state insurance code, Title 48 RCW, and the rules and regulations that relate to accounting and financial matters and affirming that the accountant will express his or her opinion on the financial statements in terms of their conformity to the statutory accounting practices prescribed or otherwise permitted by the commissioner, specifying such exceptions as he or she may believe appropriate.

(3) If an accountant who was the accountant for the immediately preceding filed audited financial report is dismissed or resigns, the insurer shall, within five business days, notify the commissioner of this event. The insurer shall also furnish the commissioner with a separate letter within ten business days of the above notification stating whether in the twenty-four months preceding such event there were any disagreements with the former accountant on any matter of accounting principles or practices, financial statement disclosure, or auditing scope or procedure; which disagreements, if not resolved to the satisfaction of the former accountant, would have caused him or her to make reference to the subject matter of the disagreement in connection with his or her opinion. The disagreements required to be reported in response to this section include both those resolved to the former accountant's satisfaction and those not resolved to the former accountant's satisfaction. Disagreements contemplated by this section are those that occur at the decision-making level, i.e., between personnel of the insurer responsible for presentation of its financial statements and personnel of the accounting firm responsible for rendering its report. The insurer shall also in writing request the former accountant to furnish a letter addressed to the insurer stating whether the accountant agrees with the statements contained in the insurer's letter and, if not, stating the reasons for which he or she does not agree; and the insurer shall furnish such responsive letter from the former accountant to the commissioner together with its own.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.05.250, 48.44.095, 48.46.080, 48.46.200, and 48.125.090. 09-20-069 (Matter No. R 2009-09), § 284-07-140, filed 10/5/09, effective 11/5/09. Statutory Authority: RCW 48.02.060, 48.43.140, 48.44.050 and 48.46.200. 94-04-045 (Order R 94-2), § 284-07-140, filed 1/27/94, effective 2/27/94. Statutory Authority: RCW 48.02.060. 92-19-040 (Order R 92-10), § 284-07-140, filed 9/9/92, effective 10/10/92.]

WAC 284-07-150 Qualifications of independent certified public accountant. (1) The commissioner shall not recognize a person or firm as a qualified independent certified public accountant if the person or firm:

(a) Is not in good standing with the American Institute of Certified Public Accountants (AICPA) and in all states in which the accountant is licensed to practice, or, for a Canadian or British company, that is not a chartered accountant; or

(b) Has either directly or indirectly entered into an agreement of indemnity or release from liability (collectively referred to as an indemnification) with respect to the audit of the insurer.

(2) Except as otherwise provided in WAC 284-07-100 through 284-07-230, the commissioner shall recognize an independent certified public accountant as qualified as long as he or she conforms to the standards of his or her profession, as contained in the Code of Professional Ethics of the American Institute of Certified Public Accountants (AICPA) and statutes (chapter 18.04 RCW) and rules (chapter 4-25 WAC) of the Washington state board of accountancy, or similar rules.

(3) A qualified independent certified public accountant may enter into any agreement with an insurer to have disputes relating to an audit resolved by mediation or arbitration. However, in the event of a delinquency proceeding commenced against the insurer under chapters 48.31 and 48.99 RCW, the mediation or arbitration provisions shall operate at the option of the statutory successor.

(4)(a) The lead (or coordinating) partner (having primary responsibility for the audit) may not act in that capacity for more than five consecutive years. The person shall be disqualified from acting in that or a similar capacity for the same company or its insurance subsidiaries or affiliates for a period of five consecutive years. An insurer may make application to the commissioner for relief from the above rotation requirement on the basis of unusual circumstances. This application must be made at least thirty days before the end of the calendar year. The commissioner may consider the following factors in determining if the relief should be granted:

(i) Number of partners, expertise of the partners, or the number of insurance clients in the currently registered firm;

(ii) Premium volume of the insurer; and

(iii) Number of jurisdictions in which the insurer transacts business.

(b) The insurer shall file, with its annual statement filing, the approval for relief from WAC 284-07-150 (4)(a) with the states that it is licensed in or doing business in and with the NAIC. If the nondomestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC.

(5) The commissioner shall not recognize as a qualified independent certified public accountant, nor accept any

annual audited financial report, prepared in whole or in part by, any natural person who:

(a) Has been convicted of fraud, bribery, a violation of the Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C.Sections 1961-1968, or any dishonest conduct or practices under federal or state law;

(b) Has been found to have violated the insurance laws of this state with respect to any previous reports submitted under WAC 284-07-100 through 284-07-230; or

(c) Has demonstrated a pattern or practice of failing to detect or disclose material information in previous reports filed under the provisions of WAC 284-07-100 through 284-07-230.

(6) The commissioner as provided in RCW 48.02.060 may hold a hearing to determine whether an independent certified public accountant is qualified and, considering the evidence presented, may rule that the accountant is not qualified for purposes of expressing his or her opinion on the financial statements in the annual audited financial report made pursuant to WAC 284-07-100 through 284-07-230 and require the insurer to replace the accountant with another whose relationship with the insurer is qualified within the meaning of WAC 284-07-100 through 284-07-230.

(7)(a) The commissioner shall not recognize as a qualified independent certified public accountant, nor accept an annual audited financial report, prepared in whole or in part by an accountant who provides to an insurer, contemporaneously with the audit, the following nonaudit services:

(i) Bookkeeping or other services related to the accounting records or financial statements of the insurer;

(ii) Financial information systems design and implementation;

(iii) Appraisal or valuation services, fairness opinions, or contribution-in-kind reports;

(iv) Actuarially oriented advisory services involving the determination of amounts recorded in the financial statements. The accountant may assist an insurer in understanding the methods, assumptions and inputs used in the determination of amounts recorded in the financial statements only if it is reasonable to conclude that the services provided will not be subject to audit procedures during an audit of the insurer's financial statements. An accountant's actuary may also issue an actuarial opinion or certification (opinion) on an insurer's reserves if the following conditions have been met:

(A) Neither the accountant nor the accountant's actuary has performed any management functions or made any management decisions;

(B) The insurer has competent personnel (or engages a third-party actuary) to estimate the reserves for which management takes responsibility; and

(C) The accountant's actuary tests the reasonableness of the reserves after the insurer's management has determined the amount of the reserves;

(v) Internal audit outsourcing services;

(vi) Management functions or human resources;

(vii) Broker or dealer, investment adviser, or investment banking services;

(viii) Legal services or expert services unrelated to the audit; or

(ix) Any other services that the commissioner determines, by rule, are impermissible.

(b) In general, the principles of independence with respect to services provided by the qualified independent certified public accountant are largely predicated on three basic principles, violations of which would impair the accountant's independence. The principles are that the accountant cannot function in the role of management, cannot audit his or her own work, and cannot serve in an advocacy role of the insurer.

(8) Insurers having direct written and assumed premiums of less than one hundred million dollars in any calendar year may request an exemption from subsection (7)(a) of this section. The insurer shall file with the commissioner a written statement discussing the reasons why the insurer should be exempt from these provisions. If the commissioner finds, upon review of this statement, that compliance with WAC 284-07-100 through 284-07-230 would constitute a financial or organizational hardship upon the insurer, an exemption may be granted.

(9) A qualified independent certified public accountant who performs the audit may engage in other nonaudit services, including tax services, that are not described in subsection (7)(a) of this section or that do not conflict with subsection (7)(b) of this section, only if the activity is approved in advance by the audit committee, in accordance with subsection (10) of this section.

(10) All auditing services and nonaudit services provided to an insurer by the qualified independent certified public accountant of the insurer shall be preapproved by the audit committee. The preapproval requirement is waived with respect to nonaudit services if the insurer is a SOX compliant entity or a direct or indirect wholly owned subsidiary of a SOX compliant entity or:

(a) The aggregate amount of all such nonaudit services provided to the insurer constitutes not more than five percent of the total amount of fees paid by the insurer to its qualified independent certified public accountant during the fiscal year in which the nonaudit services are provided;

(b) The services were not recognized by the insurer at the time of the engagement to be nonaudit services; and

(c) The services are promptly brought to the attention of the audit committee and approved prior to the completion of the audit by the audit committee or by one or more of the members of the audit committee who are the members of the board of directors to whom authority to grant such approvals has been delegated by the audit committee.

(11) The audit committee may delegate to one or more designated members of the audit committee the authority to grant the preapprovals required by subsection (10) of this section. The decisions of any member to whom this authority is delegated shall be presented to the full audit committee at each of its scheduled meetings.

(12)(a) The commissioner shall not recognize an independent certified public accountant as qualified for a particular insurer if a member of the board, president, chief executive officer, controller, chief financial officer, chief accounting officer, or any other person serving in an equivalent position for that insurer, was employed by the independent certified public accountant and participated in the audit of that insurer during the one-year period preceding the date that the most current statutory opinion is due. This section shall only apply to partners and senior managers involved in the

audit. An insurer may make application to the commissioner for relief from the above requirement on the basis of unusual circumstances.

(b) The insurer shall file, with its annual statement filing, the approval for relief from (a) of this subsection with the states that it is licensed in or doing business in and the NAIC. If the nondomestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.05.250, 48.44.095, 48.46.080, 48.46.200, and 48.125.090. 09-20-069 (Matter No. R 2009-09), § 284-07-150, filed 10/5/09, effective 11/5/09. Statutory Authority: RCW 48.02.060, 48.05.250, 48.44.050, 48.44.095, 48.46.080, 48.46.-200, and 48.125.090. 09-07-044 (Matter No. R 2008-29), § 284-07-150, filed 3/11/09, effective 4/11/09. Statutory Authority: RCW 48.02.060. 92-19-040 (Order R 92-10), § 284-07-150, filed 9/9/92, effective 10/10/92.]

WAC 284-07-160 Consolidated or combined audits. An insurer may make written application to the commissioner for approval to file audited consolidated or combined financial statements in lieu of separate annual audited financial statements if the insurer is part of a group of insurance companies which utilizes a pooling or one hundred percent reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer cedes all of its direct and assumed business to the pool. In such cases, a columnar consolidating or combining worksheet shall be filed with the report, as follows:

(1) Amounts shown on the consolidated or combined audited financial report shall be shown on the worksheet;

(2) Amounts for each insurer subject to this section shall be stated separately;

(3) Noninsurance operations may be shown on the worksheet on a combined or individual basis;

(4) Explanations of consolidating and eliminating entries shall be included; and

(5) A reconciliation shall be included of any differences between the amounts shown in the individual insurer columns of the worksheet and comparable amounts shown on the annual statements of the insurers.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.05.250, 48.44.095, 48.46.080, 48.46.200, and 48.125.090. 09-20-069 (Matter No. R 2009-09), § 284-07-160, filed 10/5/09, effective 11/5/09. Statutory Authority: RCW 48.02.060. 92-19-040 (Order R 92-10), § 284-07-160, filed 9/9/92, effective 10/10/92.]

WAC 284-07-170 Scope of audit and report of independent certified public accountant. Financial statements furnished pursuant to WAC 284-07-130 hereof shall be examined by an independent certified public accountant. The audit of the insurer's financial statements shall be conducted in accordance with generally accepted auditing standards. In accordance with AU Section 319 of the Professional Standards of the AICPA, *Consideration of Internal Control in a Financial Statement Audit*, the independent certified public accountant should obtain an understanding of internal control sufficient to plan the audit. To the extent required by AU 319, for those insurers required to file a management's report of internal control over financial reporting pursuant to WAC 284-07-217, the independent certified public accountant should consider (as that term is defined in Statement of Auditing Standards (SAS) No. 102, *Defining Professional Requirements in Statements on Auditing Standards*, or its replacement) the most recently available report in planning and performing the audit of the statutory financial statements. Consideration shall be given to the procedures illustrated in the Financial Condition Examiner's Handbook promulgated by the National Association of Insurance Commissioners as the independent certified public accountant deems necessary.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.05.250, 48.44.095, 48.46.080, 48.46.200, and 48.125.090. 09-20-069 (Matter No. R 2009-09), § 284-07-170, filed 10/5/09, effective 11/5/09. Statutory Authority: RCW 48.02.060. 92-19-040 (Order R 92-10), § 284-07-170, filed 9/9/92, effective 10/10/92.]

WAC 284-07-180 Notification of adverse financial condition. (1) The insurer required to furnish the annual audited financial report shall require the independent certified public accountant to report, in writing, within five business days to the board of directors or its audit committee any determination by the independent certified public accountant that the insurer has materially misstated its financial condition as reported to the commissioner as of the balance sheet date currently under audit or that the insurer does not meet the minimum capital and surplus or net worth requirements of the Washington state insurance code, Title 48 RCW, as of that date. An insurer that has received a report pursuant to this subsection shall forward a copy of the report to the commissioner within five business days of receipt of the report and shall provide the independent certified public accountant making the report with evidence of the report being furnished to the commissioner. If the independent certified public accountant fails to receive the evidence within the required five business day period, the independent certified public accountant shall furnish to the commissioner a copy of its report within the next five business days.

(2) No independent public accountant shall, by virtue of WAC 284-07-100 through 284-07-230, be liable in any manner to any person for any statement made in connection with subsection (1) of this section if the statement is made in good faith in compliance with subsection (1) of this section.

(3) If the accountant, subsequent to the date of the audited financial report filed pursuant to WAC 284-07-100 through 284-07-230, becomes aware of facts which might have affected his or her report, the commissioner notes the obligation of the accountant to take such action as prescribed in Volume 1, Section AU 561 of the Professional Standards of the American Institute of Certified Public Accountants (AICPA) or its replacement.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.05.250, 48.44.095, 48.46.080, 48.46.200, and 48.125.090. 09-20-069 (Matter No. R 2009-09), § 284-07-180, filed 10/5/09, effective 11/5/09. Statutory Authority: RCW 48.02.060, 48.43.140, 48.44.050 and 48.46.200. 94-04-045 (Order R 94-2), § 284-07-180, filed 1/27/94, effective 2/27/94. Statutory Authority: RCW 48.02.060. 92-19-040 (Order R 92-10), § 284-07-180, filed 9/9/92, effective 10/10/92.]

WAC 284-07-190 Communication of internal control related matters noted in an audit. (1) In addition to the annual audited financial report, each insurer shall furnish the commissioner with a written communication as to any unremediated material weaknesses in its internal controls over financial reporting noted during the audit. Such communication shall be prepared by the accountant within sixty days

after the filing of the annual audited financial report, and shall contain a description of any unremediated material weakness (as the term material weakness is defined by SAS No. 60, *Communication of Internal Control Related Matters Noted in an Audit*, or its replacement) as of December 31 immediately preceding (so as to coincide with the audited financial report discussed in WAC 284-07-120(1)) in the insurer's internal control over financial reporting noted by the accountant during the course of their audit of the financial statements. If no unremediated material weaknesses were noted, the communication should so state.

(2) The insurer is required to provide a description of remedial actions taken or proposed to correct unremediated material weaknesses, if such actions are not described in the accountant's communication.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.05.250, 48.44.095, 48.46.080, 48.46.200, and 48.125.090. 09-20-069 (Matter No. R 2009-09), § 284-07-190, filed 10/5/09, effective 11/5/09. Statutory Authority: RCW 48.02.060. 92-19-040 (Order R 92-10), § 284-07-190, filed 9/9/92, effective 10/10/92.]

WAC 284-07-200 Accountant's letter of qualifications. The accountant shall furnish the insurer in connection with, and for inclusion in, the filing of the annual audited financial report, a letter stating:

(1) That the accountant is independent with respect to the insurer and conforms to the standards of his or her profession as contained in the Code of Professional Ethics and pronouncements of the American Institute of Certified Public Accountants (AICPA) and the statutes (chapter 18.04 RCW) and rules (chapter 4-25 WAC) of the Washington state board of accountancy, or similar rules;

(2) The background and experience in general, and the experience in audits of insurers of the staff assigned to the engagement and whether each is an independent certified public accountant. Nothing within WAC 284-07-100 through 284-07-230 shall be construed as prohibiting the accountant from utilizing such staff as he or she deems appropriate where use is consistent with the standards prescribed by generally accepted auditing standards;

(3) That the accountant understands the annual audited financial report and his or her opinion thereon will be filed in compliance with WAC 284-07-100 through 284-07-230 and that the commissioner will be relying on this information in the monitoring and regulation of the financial position of insurers;

(4) That the accountant consents to the requirements of WAC 284-07-210 and that the accountant consents and agrees to make available for review by the commissioner, or the commissioner's designee or appointed agent, the workpapers, as defined in WAC 284-07-210;

(5) A representation that the accountant is properly licensed by an appropriate state licensing authority and is a member in good standing in the American Institute of Certified Public Accountants (AICPA); and

(6) A representation that the accountant is in compliance with the requirements of WAC 284-07-150.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.05.250, 48.44.095, 48.46.080, 48.46.200, and 48.125.090. 09-20-069 (Matter No. R 2009-09), § 284-07-200, filed 10/5/09, effective 11/5/09. Statutory Authority: RCW 48.02.060. 92-19-040 (Order R 92-10), § 284-07-200, filed 9/9/92, effective 10/10/92.]

WAC 284-07-210 Definition, availability, and maintenance of independent certified public accountants workpapers. (1) Workpapers are the records kept by the independent certified public accountant of the procedures followed, the tests performed, the information obtained, and the conclusions reached pertinent to the accountant's audit of the financial statements of an insurer. Workpapers, accordingly, may include audit planning documentation, work programs, analyses, memoranda, letters of confirmation and representation, abstracts of company documents and schedules or commentaries prepared or obtained by the independent certified public accountant in the course of his or her audit of the financial statements of an insurer and which support the accountant's opinion.

(2) Every insurer required to file an audited financial report pursuant to WAC 284-07-100 through 284-07-230, shall require the accountant to make available for review by the commissioner's examiners, all workpapers prepared in the conduct of the accountant's audit and any communications related to the audit between the accountant and the insurer, at the offices of the insurer, at the commissioner's office or at any other reasonable place designated by the commissioner. The insurer shall require that the accountant retain the audit workpapers and communications until the commissioner has filed a report on examination covering the period of the audit but no longer than seven years from the date of the audit report.

(3) In the conduct of the aforementioned periodic review by the commissioner's examiners, it shall be agreed that photocopies of pertinent audit workpapers may be made and retained by the commissioner's office. Such reviews by the commissioner's examiners shall be considered investigations and all working papers and communications obtained during the course of such investigations shall be afforded the same confidentiality as other examination workpapers generated by the insurance commissioner.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.05.250, 48.44.095, 48.46.080, 48.46.200, and 48.125.090. 09-20-069 (Matter No. R 2009-09), § 284-07-210, filed 10/5/09, effective 11/5/09. Statutory Authority: RCW 48.02.060. 92-19-040 (Order R 92-10), § 284-07-210, filed 9/9/92, effective 10/10/92.]

WAC 284-07-213 Requirements for audit committees. This section shall not apply to foreign or alien insurers licensed in this state or an insurer that is a SOX compliant entity or a direct or indirect wholly owned subsidiary of a SOX compliant entity.

(1) The audit committee shall be directly responsible for the appointment, compensation and oversight of the work of any accountant (including resolution of disagreements between management and the accountant regarding financial reporting) for the purpose of preparing or issuing the audited financial report or related work pursuant to WAC 284-07-100 through 284-07-230. Each accountant shall report directly to the audit committee.

(2) Each member of the audit committee shall be a member of the board of directors of the insurer or a member of the board of directors of an entity elected pursuant to subsection (5) of this section and WAC 284-07-110(3).

(3) In order to be considered independent for purposes of this section, a member of the audit committee may not, other

than in his or her capacity as a member of the audit committee, the board of directors, or any other board committee, accept any consulting, advisory or other compensatory fee from the entity or be an affiliated person of the entity or any subsidiary thereof. However, if law requires board participation by otherwise nonindependent members, that law shall prevail and the members may participate in the audit committee and be designated as independent for audit committee purposes, unless they are an officer or employee of the insurer or one of its affiliates.

(4) If a member of the audit committee ceases to be independent for reasons outside the member's reasonable control, that person, with notice by the responsible entity to the state, may remain an audit committee member for the responsible entity until the earlier of the next annual meeting of the responsible entity or one year from the occurrence of the event that caused the member to be no longer independent.

(5) To exercise the election of the controlling person to designate the audit committee for purposes of WAC 284-07-100 through 284-07-230, the ultimate controlling person shall provide written notice to the commissioners of the affected insurers. Notification shall be made timely prior to the issuance of the statutory audit report and include a description of the basis for the election. The election can be changed through notice to the commissioner by the insurer, which shall include a description of the basis for the change. The election shall remain in effect for perpetuity, until rescinded.

(6)(a) The audit committee shall require the accountant that performs for an insurer any audit required by WAC 284-07-100 through 284-07-230 to timely report to the audit committee in accordance with the requirements of SAS 61, *Communication with Audit Committees*, or its replacement, including:

(i) All significant accounting policies and material permitted practices;

(ii) All material alternative treatments of financial information within statutory accounting principles that have been discussed with management officials of the insurer, ramifications of the use of the alternative disclosures and treatments, and the treatment preferred by the accountant; and

(iii) Other material written communications between the accountant and the management of the insurer, such as any management letter or schedule of unadjusted differences.

(b) If an insurer is a member of an insurance or health carrier holding company system, the reports required by (a) of this subsection may be provided to the audit committee on an aggregate basis for insurers in the holding company system, provided that any substantial differences among insurers in the system are identified to the audit committee.

(7) The proportion of independent audit committee members shall meet or exceed the following criteria:

Prior Calendar Year Direct Written and Assumed Premiums		
$0 - $300,000,000	**Over $300,000,000 - $500,000,000**	**Over $500,000,000**
No minimum requirements. See also Note A and B.	Majority (50% or more) of members shall be independent. See also Note A and B.	Supermajority of members (75% or more) shall be independent. See also Note A.

Note A: The commissioner has authority by state law to require the entity's board to enact improvements to the independence of the audit committee membership if the insurer is in a RBC action level event, meets one or more of the standards of an insurer deemed to be in hazardous financial condition, or otherwise exhibits qualities of a troubled insurer.

Note B: All insurers with less than five hundred million dollars in prior year direct written and assumed premiums are encouraged to structure their audit committees with at least a supermajority of independent audit committee members.

Note C: Prior calendar year direct written and assumed premiums shall be the combined total of direct premiums and assumed premiums from nonaffiliates for the reporting entities.

(8) An insurer with direct written and assumed premiums, excluding premiums reinsured with the Federal Crop Insurance Corporation and federal flood program, less than five hundred million dollars may make application to the commissioner for a waiver from this section's requirements based upon hardship. The insurer shall file, with its annual statement filing, the approval for relief from this section with the states that it is licensed in or doing business in and the NAIC. If the nondomestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.05.250, 48.44.095, 48.46.080, 48.46.200, and 48.125.090. 09-20-069 (Matter No. R 2009-09), § 284-07-213, filed 10/5/09, effective 11/5/09.]

WAC 284-07-215 Conduct of insurers in connection with the preparation of required reports and documents. (1) No director or officer of an insurer shall, directly or indirectly:

(a) Make or cause to be made a materially false or misleading statement to an accountant in connection with any audit, review or communication required under WAC 284-07-100 through 284-07-230; or

(b) Omit to state, or cause another person to omit to state, any material fact necessary in order to make statements made, in light of the circumstances under which the statements were made, not misleading to an accountant in connection with any audit, review or communication required under WAC 284-07-100 through 284-07-230.

(2) No officer or director of an insurer, or any other person acting under the direction thereof, shall directly or indirectly take any action to coerce, manipulate, mislead or fraudulently influence any accountant engaged in the performance of an audit pursuant to WAC 284-07-100 through 284-07-230 if that person knew or should have known that the action, if successful, could result in rendering the insurer's financial statements materially misleading.

(3) For purposes of subsection (2) of this section, actions that, "if successful, could result in rendering the insurer's financial statements materially misleading" include, but are not limited to, actions taken at any time with respect to the professional engagement period to coerce, manipulate, mislead or fraudulently influence an accountant:

(a) To issue or reissue a report on an insurer's financial statements that is not warranted in the circumstances (due to material violations of statutory accounting principles prescribed by the commissioner, generally accepted auditing standards, or other professional or regulatory standards);

(b) Not to perform audit, review or other procedures required by generally accepted auditing standards or other professional standards;

(c) Not to withdraw an issued report; or

(d) Not to communicate matters to an insurer's audit committee.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.05.250, 48.44.095, 48.46.080, 48.46.200, and 48.125.090. 09-20-069 (Matter No. R 2009-09), § 284-07-215, filed 10/5/09, effective 11/5/09.]

WAC 284-07-217 Management's report of internal control over financial reporting. (1) Every insurer required to file an audited financial report pursuant to WAC 284-07-100 through 284-07-230 that has annual direct written and assumed premiums, excluding premiums reinsured with the Federal Crop Insurance Corporation and federal flood program, of five hundred million dollars or more shall prepare a report of the insurer's or group of insurers' internal control over financial reporting, as these terms are defined in WAC 284-07-110. The report shall be filed with the commissioner along with the *Communications of Internal Control Related Matters Noted in an Audit* described under WAC 284-07-190. Management's report of internal control over financial reporting shall be as of December 31 immediately preceding.

(2) Notwithstanding the premium threshold in subsection (1) of this section, the commissioner may require an insurer to file management's report of internal control over financial reporting if the insurer is in any RBC level event, or meets any one or more of the standards of an insurer deemed to be in hazardous financial condition as defined in WAC 284-16-310.

(3) An insurer or group of insurers that is:

(a) Directly subject to Section 404;

(b) Part of a holding company system whose parent is directly subject to Section 404;

(c) Not directly subject to Section 404 but is a SOX compliant entity; or

(d) A member of a holding company system whose parent is not directly subject to Section 404 but is a SOX compliant entity may file its or its parent's Section 404 Report and an addendum in satisfaction of this section's requirement provided that those internal controls of the insurer or group of insurers having a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements (those items included in WAC 284-07-130 (2)(b) through (g)) were included in the scope of the Section 404 Report. The addendum shall be a positive statement by management that there are no material processes with respect to the preparation of the insurer's or group of insurers' audited statutory financial statements (those items included in WAC 284-07-130 (2)(b) through (g)) excluded from the Section 404 Report. If there are internal controls of the insurer or group of insurers that have a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements and those internal controls were not included in the scope of the Section 404 Report, the insurer or group of insurers may either file:

(i) A WAC 284-07-217 report; or

(ii) The Section 404 Report and a WAC 284-07-217 report for those internal controls that have a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements not covered by the Section 404 Report.

(4) Management's report of internal control over financial reporting shall include:

(a) A statement that management is responsible for establishing and maintaining adequate internal control over financial reporting;

(b) A statement that management has established internal control over financial reporting and an assertion, to the best of management's knowledge and belief, after diligent inquiry, as to whether its internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles;

(c) A statement that briefly describes the approach or processes by which management evaluated the effectiveness of the internal control over financial reporting;

(d) A statement that briefly describes the scope of work that is included and whether any internal controls were excluded;

(e) Disclosure of any unremediated material weaknesses in the internal control over financial reporting identified by management as of December 31 immediately preceding. Management is not permitted to conclude that the internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles if there is one or more unremediated material weakness in its internal control over financial reporting;

(f) A statement regarding the inherent limitations of internal control systems; and

(g) Signatures of the chief executive officer and the chief financial officer (or equivalent position/title).

(5) Management shall document and make available upon financial condition examination the basis upon which its assertions, required in subsection (4) of this section, are made. Management may base its assertions, in part, upon review, monitoring and testing of internal controls undertaken in the normal course of its activities.

(a) Management shall have discretion as to the nature of the internal control framework used, and the nature and extent of documentation, in order to make its assertion in a cost-effective manner and, as such, may include assembly of or reference to existing documentation.

(b) Management's report on internal control over financial reporting, required by subsection (1) of this section, and any documentation provided in support thereof during the course of a financial condition examination, shall, to the extent provided by law, be kept confidential by the commissioner.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.05.250, 48.44.095, 48.46.080, 48.46.200, and 48.125.090. 09-20-069 (Matter No. R 2009-09), § 284-07-217, filed 10/5/09, effective 11/5/09.]

WAC 284-07-220 Exemptions and effective dates. (1) Upon written application of any insurer, the commissioner may grant an exemption from compliance with any and all provisions of WAC 284-07-100 through 284-07-230 if the commissioner finds, upon review of the application, that compliance with WAC 284-07-100 through 284-07-230 would constitute a financial or organizational hardship upon the insurer. An exemption may be granted at any time and from time to time for a specified period or periods. Within ten

days from a denial of an insurer's written request for an exemption from WAC 284-07-100 through 284-07-230, the insurer may request in writing a hearing on its application for an exemption. The hearing shall be held in accordance with the rules and procedures pertaining to administrative hearings.

(2) Domestic insurers retaining a certified public accountant on the effective date of WAC 284-07-100 through 284-07-230 who qualify as independent shall comply with WAC 284-07-100 through 284-07-230 for the year ending December 31, 1992, and each year thereafter unless the commissioner permits otherwise.

(3) Domestic insurers not retaining a certified public accountant on the effective date of WAC 284-07-100 through 284-07-230 who qualify as independent may meet the following schedule for compliance unless the commissioner permits otherwise.

(a) As of December 31, 1992, file with the commissioner an audited financial report.

(b) For the year ending December 31, 1992, and each year thereafter, the insurers shall file with the commissioner all reports and communications required by WAC 284-07-100 through 284-07-210.

(4) Foreign insurers shall comply with WAC 284-07-100 through 284-07-230 for the year ending December 31, 1992, and each year thereafter, unless the commissioner permits otherwise.

(5) The requirements of WAC 284-07-150(4) shall be in effect for audits of the year beginning January 1, 2010 and thereafter.

(6) The requirements of WAC 284-07-213 are to be in effect January 1, 2010. An insurer or group of insurers that is not required to have independent audit committee members or only a majority of independent audit committee members (as opposed to a supermajority) because the total written premium and assumed premium is below the threshold and subsequently becomes subject to one of the independence requirements due to change in premiums shall have one year following the year the threshold is exceeded (but not later than January 1, 2010) to comply with the independence requirements. Likewise, an insurer that becomes subject to one of the independence requirements as a result of business combination shall have one calendar year following the date of acquisition or combination to comply with the independence requirements.

(7) The requirements of WAC 284-07-150 (7) through (12), 284-07-190, 284-07-215, and 284-07-217 are effective beginning with the reporting period ending December 31, 2010 and each year thereafter. An insurer or group of insurers that is not required to file a report because the total written premium is below the threshold and subsequently becomes subject to the reporting requirements shall have two years following the year the threshold is exceeded (but not earlier than December 31, 2010) to file a report. Likewise, an insurer acquired in a business combination shall have two calendar years following the date of acquisition or combination to comply with the reporting requirements.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.05.250, 48.44.095, 48.46.080, 48.46.200, and 48.125.090. 09-20-069 (Matter No. R 2009-09), § 284-07-220, filed 10/5/09, effective 11/5/09. Statutory Authority: RCW 48.02.060, 48.43.140, 48.44.050 and 48.46.200. 94-04-045 (Order R 94-2), § 284-07-220, filed 1/27/94, effective 2/27/94. Statutory Authority: RCW 48.02.060. 92-19-040 (Order R 92-10), § 284-07-220, filed 9/9/92, effective 10/10/92.]

WAC 284-07-230 Canadian and British companies. (1) In the case of Canadian and British insurers, the annual audited financial report shall be defined as the annual statement of total business on the form filed by the companies with their supervision authority duly audited by an independent chartered accountant.

(2) For the insurers, the letter required in WAC 284-07-140(2) shall state that the accountant is aware of the requirements relating to the annual audited report filed with the commissioner pursuant to WAC 284-07-120 and shall affirm that the opinion expressed is in conformity with those requirements.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.05.250, 48.44.095, 48.46.080, 48.46.200, and 48.125.090. 09-20-069 (Matter No. R 2009-09), § 284-07-230, filed 10/5/09, effective 11/5/09. Statutory Authority: RCW 48.02.060. 92-19-040 (Order R 92-10), § 284-07-230, filed 9/9/92, effective 10/10/92.]

WAC 284-07-240 Severability provision. If any provision of WAC 284-07-100 through 284-07-230 or its application to any person or circumstances is held invalid, the remainder of WAC 284-07-100 through 284-07-230 or the application of the provision to other persons or circumstances is not affected.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.05.250, 48.44.095, 48.46.080, 48.46.200, and 48.125.090. 09-20-069 (Matter No. R 2009-09), § 284-07-240, filed 10/5/09, effective 11/5/09.]

WAC 284-07-500 Definitions. For purposes of this rule:

(1) A "permitted accounting practice" is an accounting practice that departs from the National Association of Insurance Commissioners (NAIC) *Accounting Practices and Procedures Manual* or state prescribed accounting practices, and has been approved in writing by the commissioner.

(2) "State prescribed accounting practices" are those accounting practices that are incorporated directly or by reference by Titles 48 RCW and 284 WAC applicable to domestic insurers.

(3) A "domestic insurer" includes an entity organized under the laws of this state as an insurer authorized under chapter 48.05 RCW, a fraternal benefit society licensed under chapter 48.36A RCW, a health care service contractor registered under chapter 48.44 RCW, a health maintenance organization registered under chapter 48.46 RCW, a self-funded multiple employer welfare arrangement authorized under chapter 48.125 RCW, or other entity regulated under Title 48 RCW and required to comply with the NAIC *Accounting Practices and Procedures Manual* and state prescribed accounting practices.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 09-03-102 (Matter No. R 2008-26), § 284-07-500, filed 1/21/09, effective 2/21/09.]

WAC 284-07-510 Prior approval required for a domestic insurer to use permitted accounting practice. (1) If a domestic insurer wishes to use a permitted accounting practice, the domestic insurer must obtain prior written

approval of the permitted accounting practice from the commissioner.

(2) An insurer must submit its request for a permitted accounting practice to the commissioner in writing.

(3) A request for a permitted accounting practice must be received by the commissioner more than thirty days prior to its proposed effective date and may not be used until thirty days after the commissioner has approved the practice in writing. For good cause shown, the commissioner may reduce either time period.

(4) Instructions as to how and where a domestic insurer must send its request for a permitted accounting practice to the commissioner may be found on the commissioner's web site at www.insurance.wa.gov.

(5) The insurer may not implement any permitted practice prior to written approval by the commissioner.

(6) An insurer may use only those permitted accounting practices which have been specifically approved for that insurer and only for the time period permitted by the commissioner.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 09-03-102 (Matter No. R 2008-26), § 284-07-510, filed 1/21/09, effective 2/21/09.]

WAC 284-07-520 Information to be included in a permitted accounting practice request. A request for a permitted accounting practice must contain, at a minimum, all of the following information:

(1) The proposed effective date and the date of the first filed financial statement in which the proposed permitted accounting practice will be reported;

(2) A detailed description of the permitted accounting practice being requested, including specific citation to the NAIC *Accounting Practices and Procedures Manual* or state prescribed accounting practices from which the proposed permitted accounting practice will depart;

(3) The periods, if any, in which the proposed permitted accounting practice was previously in effect;

(4) The period in which the proposed permitted accounting practice will be effective (e.g., specific beginning and ending dates);

(5) Specific identification of each financial statement line item and its respective impact from the proposed permitted accounting practice. The respective impact must compare the financial statements prepared in accordance with RCW 48.05.073, 48.36A.263, 48.43.097, or 48.125.090(2) and financial statements incorporating the permitted accounting practices;

(6) The total financial impact on the capital and surplus of the proposed permitted accounting practice and any other previously granted permitted accounting practices. The total impact must compare the financial statements prepared in accordance with RCW 48.05.073, 48.36A.263, 48.43.097, or 48.125.090(2) and financial statements incorporating the permitted accounting practice; and

(7) The capital and surplus effect of the proposed permitted accounting practice, on a legal entity basis, on the domestic insurer, its ultimate and intermediate parents and all affiliated United States insurers. The capital and surplus effect must compare the financial statements prepared in accordance with RCW 48.05.073, 48.36A.263, 48.43.097, or 48.125.090(2) and financial statements incorporating the permitted accounting practice on a legal entity basis on the domestic insurer, its ultimate and intermediate parents and all affiliated United States insurers.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 09-03-102 (Matter No. R 2008-26), § 284-07-520, filed 1/21/09, effective 2/21/09.]

WAC 284-07-530 Expiration of a permitted accounting practice. The commissioner may only approve a request to use a permitted accounting practice for up to one calendar year. All permitted practices will expire no later than December 31. An insurer wishing to continue the permitted practice must file a new permitted practice request with the commissioner. Permitted accounting practices that were previously approved by the commissioner that remain in effect as of the effective date of this rule which do not have a specific termination date will expire upon any change of control of the insurer or December 31, 2010, whichever occurs first.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 09-03-102 (Matter No. R 2008-26), § 284-07-530, filed 1/21/09, effective 2/21/09.]

Chapter 284-12 WAC
AGENTS, BROKERS AND ADJUSTERS

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-12-090 When general agent may accept applications from nonappointed agents. [Statutory Authority: RCW 48.01.030, 48.02.060(3), 48.14.010 and 48.17.500(3). 94-14-110 (Order R 94-14), § 284-12-090, filed 7/6/94, effective 8/6/94. Statutory Authority: RCW 48.02.060, 48.05.310, 48.30.010 and 48.15.080. 91-23-032 (Order R 91-7), § 284-12-090, filed 11/13/91, effective 1/1/92.] Repealed by 09-02-073 (Matter No. R 2008-06), filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.005.

Chapter 284-13 WAC
ASSETS—LIABILITIES—INVESTMENTS AND REINSURANCE

WAC

WAC 284-13-700 Definitions. (1) Terms used in this regulation (WAC 284-13-700 through 284-13-760) that are defined in the Reinsurance Intermediary Act chapter 48.94 RCW ("the act") have the meaning stated there.

(2) Whether a person is an "employee" of the reinsurer for purposes of RCW 48.94.005 (7)(a) depends on the facts and is not controlled by a mere labeling of the person as an employee in an agreement.

(3) A reinsurer is "licensed in this state" for purposes of RCW 48.94.005(8) when it holds a certificate of authority to transact the relevant line of insurance.

[Statutory Authority: RCW 48.02.060, 48.94.055, and 48.94.010. 09-24-102 (Matter No. R 2009-11), § 284-13-700, filed 12/2/09, effective 1/2/10. Stat-

utory Authority: RCW 48.02.060 and 1993 c 462 § 33. 93-19-011 (Order R 93-15), § 284-13-700, filed 9/1/93, effective 10/2/93.]

WAC 284-13-715 Changes to information contained in an application for license. A licensed reinsurance intermediary must notify the commissioner within fifteen business days after occurrence of material changes to the information that was included in the application. For example this includes, but is not limited to, a change to:

(1) The reinsurance intermediary's legal name;

(2) The reinsurance intermediary's formation documents if it is a business entity;

(3) The reinsurance intermediary's registered address;

(4) Individuals authorized to act under the license; and

(5) The reinsurance intermediary's designation to receive service of process.

[Statutory Authority: RCW 48.02.060, 48.94.055, and 48.94.010. 09-24-102 (Matter No. R 2009-11), § 284-13-715, filed 12/2/09, effective 1/2/10.]

WAC 284-13-720 Financial statement of reinsurance intermediary-manager. A reinsurer shall obtain from each reinsurance intermediary-manager, and a reinsurance intermediary-manager shall give to the reinsurer, annual statements of financial condition prepared by an independent certified public accountant. The form of the statements shall be such that the statements clearly show the results of operations, and the assets, liabilities, and equity of the reinsurance intermediary-manager. Nothing in the act or this regulation (WAC 284-13-700 through 284-13-760) prevents a reinsurer from requiring additional information, more detail, or a specified format so long as that specified format at least meets the requirements of this section.

[Statutory Authority: RCW 48.02.060, 48.94.055, and 48.94.010. 09-24-102 (Matter No. R 2009-11), § 284-13-720, filed 12/2/09, effective 1/2/10. Statutory Authority: RCW 48.02.060 and 1993 c 462 § 33. 93-19-011 (Order R 93-15), § 284-13-720, filed 9/1/93, effective 10/2/93.]

WAC 284-13-730 Submission and approval of contracts between reinsurers and reinsurance intermediary—Managers. Contracts filed for approval under RCW 48.94.030 must include the provisions required by that section. If those provisions are not in the order given in that section, or if any other provisions precede or separate any of those required provisions, then the submitted contract shall be accompanied by a statement showing where in the contract each required provision is.

[Statutory Authority: RCW 48.02.060, 48.94.055, and 48.94.010. 09-24-102 (Matter No. R 2009-11), § 284-13-730, filed 12/2/09, effective 1/2/10. Statutory Authority: RCW 48.02.060 and 1993 c 462 § 33. 93-19-011 (Order R 93-15), § 284-13-730, filed 9/1/93, effective 10/2/93.]

WAC 284-13-740 Reporting of claims. The reporting threshold under RCW 48.94.030 (9)(b)(v) is the lesser of fifty thousand dollars or an amount set by the reinsurer.

[Statutory Authority: RCW 48.02.060, 48.94.055, and 48.94.010. 09-24-102 (Matter No. R 2009-11), § 284-13-740, filed 12/2/09, effective 1/2/10. Statutory Authority: RCW 48.02.060 and 1993 c 462 § 33. 93-19-011 (Order R 93-15), § 284-13-740, filed 9/1/93, effective 10/2/93.]

WAC 284-13-750 Reporting of discipline in another jurisdiction. A reinsurance intermediary, or a pending applicant, must notify the commissioner within fifteen business days of a disciplinary action taken against it by another governmental jurisdiction.

[Statutory Authority: RCW 48.02.060, 48.94.055, and 48.94.010. 09-24-102 (Matter No. R 2009-11), § 284-13-750, filed 12/2/09, effective 1/2/10.]

WAC 284-13-760 Reporting of a felony conviction. A person holding a reinsurance intermediary license, or a pending applicant, convicted of any felony involving dishonesty or a breach of trust, or convicted of an offense under the Violent Crime Control and Law Enforcement Act of 1994 (108 Stat. 2115; 18 U.S.C. Sec. 1033) must notify the commissioner of the conviction within fifteen business days after the conviction.

[Statutory Authority: RCW 48.02.060, 48.94.055, and 48.94.010. 09-24-102 (Matter No. R 2009-11), § 284-13-760, filed 12/2/09, effective 1/2/10.]

Chapter 284-15 WAC
SURPLUS LINE INSURANCE

WAC

WAC 284-15-010 Brokers—Surplus line brokers—Qualifications and examination. (1) Each applicant for a resident surplus line broker's license must take and pass the required examination and pay the required fee prior to acting as a surplus line broker. The examination will test an applicant's qualifications and competence in all areas of surplus line insurance. Current information about testing procedures and examination dates is available on the commissioner's web site at: www.insurance.wa.gov.

(2) Before the commissioner can issue a surplus line broker's license, the applicant must be licensed in this state as an insurance producer with both property and casualty lines of authority. This requirement may be satisfied if the licenses are issued simultaneously.

(3) The commissioner deems that a nonresident person holding a surplus line broker's license, or the equivalent, in the applicant's home state is qualified, competent and trustworthy and, therefore, meets the minimum standards of this state for holding a surplus line broker's license. For that reason, the commissioner will waive the Washington surplus line broker's examination for a person who has and maintains a current resident surplus line broker's license, or the equivalent, in the applicant's home state.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-15-010, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.15.040(4), 48.15.073(2), and 48.15.160(2). 08-14-169 (Matter No. R 2008-04), § 284-15-010, filed 7/2/08, effective 8/2/08. Statutory Authority: RCW 48.02.060. 81-03-082 (Order R 81-1), § 284-15-010, filed 1/21/81.]

WAC 284-15-080 Relationship between surplus line broker and insurance producer not acting as the agent of the insured. When a surplus line broker accepts surplus line business from an insurance producer not acting as an agent of the insured, as permitted by RCW 48.15.080, acceptance of the business does not mean that the insurance producer has

become the representative of the insured with respect to that business. In this circumstance:

(1) Return premiums or claim payments will not be deemed to have been paid to the insured or claimant until the payments are actually received by the insured or claimant.

(2) Delivery of notices involving the insurance, such as cancellation or renewal notices, will not be deemed to have been made until actually received by the insured.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-15-080, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.15.040(4), 48.15.073(2), and 48.15.160(2). 08-14-169 (Matter No. R 2008-04), § 284-15-080, filed 7/2/08, effective 8/2/08. Statutory Authority: RCW 48.02.060, 48.05.310, 48.30.010 and 48.15.080. 91-23-032 (Order R 91-7), § 284-15-080, filed 11/13/91, effective 1/1/92.]

Chapter 284-16 WAC
INSURERS

WAC

WAC 284-16-300 Purpose. (1) The purpose of this regulation, WAC 284-16-300 through 284-16-320 is to set forth the standards which the commissioner will use to identify insurers in such condition as to render the continuance of their business hazardous to their policyholders, creditors or to the general public.

(2) This regulation shall not be interpreted to limit the powers granted the commissioner by any laws or parts of laws of this state, nor shall this regulation be interpreted to supersede any laws or parts of laws of this state.

[Statutory Authority: RCW 48.02.060, 48.31.435, 48.44.050, and 48.46.-200. 09-24-053 (Matter No. R 2009-06), § 284-16-300, filed 11/24/09, effective 12/25/09. Statutory Authority: RCW 48.02.060. 92-19-039 (Order R 92-9), § 284-16-300, filed 9/9/92, effective 10/10/92.]

WAC 284-16-310 Standards. The following standards, either singly or a combination of two or more, may be considered by the commissioner to determine whether the continued operation of any insurer transacting an insurance business in this state might be deemed to be hazardous to its policyholders, creditors, or the general public. The commissioner may consider:

(1) Adverse findings reported in financial condition reports, market conduct examination reports, audit reports, or actuarial opinions, reports or summaries.

(2) The National Association of Insurance Commissioners Insurance Regulatory Information System and its other financial analysis solvency tools and reports.

(3) Whether the insurer has made adequate provision, according to presently accepted actuarial standards of practice, for the anticipated cash flows required by the contractual obligations and related expenses of the insurer, when considered in light of the assets held by the insurer with respect to such reserves and related actuarial items including, but not limited to, the investment earnings on such assets, and the considerations anticipated to be received and retained under such policies and contracts.

(4) The ability of an assuming reinsurer to perform and whether the insurer's reinsurance program provides sufficient protection for the insurer's remaining surplus after taking into account the insurer's cash flow and the classes of business written as well as the financial condition of the assuming reinsurer.

(5) Whether the insurer's operating loss in the last twelve month period or any shorter period of time, including but not limited to net capital gain or loss, change in nonadmitted assets, and cash dividends paid to shareholders, is greater than fifty percent of such insurer's remaining surplus as regards policyholders in excess of the minimum required.

(6) Whether the insurer's operating loss in the last twelve-month period or any shorter period of time, excluding net capital gains, is greater than twenty percent of the insurer's remaining surplus as regards policyholders in excess of the minimum required.

(7) Whether a reinsurer, obligor or any entity within the insurer's insurance holding company system is insolvent, threatened with insolvency, or delinquent in payment of its monetary or other obligation, and which in the opinion of the commissioner may affect the solvency of the insurer.

(8) Contingencies, pledges, or guaranties which either individually or collectively involve a total amount which in the opinion of the commissioner may affect the solvency of the insurer.

(9) Whether any "controlling person" of an insurer is delinquent in the transmitting to, or payment of, net premiums to such insurer.

(10) The age and collectibility of receivables.

(11) Whether the management of an insurer, including officers, directors, or any other person who directly or indirectly controls the operation of such insurer, fails to possess and demonstrate the competence, fitness, and reputation deemed necessary to serve the insurer in such position.

(12) Whether management of an insurer has failed to respond to inquiries relative to the condition of the insurer or has furnished false or misleading information concerning an inquiry.

(13) Whether the insurer has failed to meet financial and holding company filing requirements in the absence of a reason satisfactory to the commissioner.

(14) Whether management of an insurer either has filed any false or misleading sworn financial statement, or has released false or misleading financial statement to lending institutions or to the general public, or has made a false or misleading entry, or has omitted an entry of material amount in the books of the insurer.

(15) Whether the insurer has grown so rapidly and to such an extent that it lacks adequate financial or administrative capacity to meet its obligations in a timely manner.

(16) Whether the insurer has experienced or will experience in the foreseeable future, cash flow or liquidity problems.

(17) Whether management has established reserves that do not comply with minimum standards established by state insurance laws, regulations, statutory accounting standards, or sound actuarial principles and standards of practice.

(18) Whether management persistently engages in material under reserving that results in adverse development.

(19) Whether transactions among affiliates, subsidiaries or controlling persons for which the insurer receives assets or capital gains, or both, do not provide sufficient value, liquidity or diversity to assure the insurer's ability to meet its outstanding obligations as they mature.

(20) Any other factor determined by the commissioner to be hazardous to the insurer's policyholders, creditors or general public.

[Statutory Authority: RCW 48.02.060, 48.31.435, 48.44.050, and 48.46.200. 09-24-053 (Matter No. R 2009-06), § 284-16-310, filed 11/24/09, effective 12/25/09. Statutory Authority: RCW 48.02.060. 92-19-039 (Order R 92-9), § 284-16-310, filed 9/9/92, effective 10/10/92.]

WAC 284-16-320 Manner in which commissioner will exercise authority. (1) For the purpose of making a determination of an insurer's financial condition under this regulation, the commissioner may:

(a) Disregard any credit or amount receivable resulting from transactions with a reinsurer which is insolvent, impaired, or otherwise subject to a delinquency proceeding;

(b) Make appropriate adjustments including disallowance to asset values attributable to investments in or transactions with parents, subsidiaries, or affiliates consistent with the *NAIC Accounting Policies and Procedures Manual*, state laws or regulations;

(c) Refuse to recognize the stated value of accounts receivable if the ability to collect receivables is highly speculative in view of the age of the account or the financial condition of the debtor; or

(d) Increase the insurer's liability in an amount equal to any contingent liability, pledge, or guarantee not otherwise included if there is a substantial risk that the insurer will be called upon to meet the obligation undertaken within the next twelve-month period.

(2) If the commissioner determines that the continued operation of the insurer authorized to transact business in this state may be hazardous to its policyholders, creditors or the general public, then the commissioner may, in conjunction with or in lieu of a notice required or permitted by RCW 48.05.150, issue an order requiring the insurer to:

(a) Reduce the total amount of present and potential liability for policy benefits by reinsurance;

(b) Reduce, suspend, or limit the volume of business being accepted or renewed;

(c) Reduce general insurance and commission expenses by specified methods;

(d) Increase the insurer's capital and surplus;

(e) Suspend or limit the declaration and payment of dividend by an insurer to its stockholders or to its policyholders;

(f) File reports in a form acceptable to the commissioner concerning the market value of an insurer's assets;

(g) Limit or withdraw from certain investments or discontinue certain investment practices to the extent the commissioner deems necessary;

(h) Document the adequacy of premium rates in relation to the risks insured;

(i) File, in addition to regular annual statements, interim financial reports on the form adopted by the National Association of Insurance Commissioners or in such format as promulgated by the commissioner;

(j) Correct corporate governance practice deficiencies, and adopt and utilize governance practices acceptable to the commissioner;

(k) Provide a business plan to the commissioner in order to continue to transact business in the state; or

(l) Notwithstanding any other provision of law limiting the frequency or amount of premium rate adjustments, adjust rates for any nonlife insurance product written by the insurer that the commissioner considers necessary to improve the financial condition of the insurer.

If the insurer is a foreign insurer, the commissioner's order may be limited to the extent provided by statute.

(3) Any insurer subject to an order under subsection (2) of this section may make a written demand for a hearing, subject to the requirements of RCW 48.04.010, by specifying in what respects it is aggrieved and the grounds to be relied upon as basis for the relief to be demanded at the hearing.

[Statutory Authority: RCW 48.02.060, 48.31.435, 48.44.050, and 48.46.200. 09-24-053 (Matter No. R 2009-06), § 284-16-320, filed 11/24/09, effective 12/25/09. Statutory Authority: RCW 48.02.060. 92-19-039 (Order R 92-9), § 284-16-320, filed 9/9/92, effective 10/10/92.]

WAC 284-16-600 Purpose. The purpose of this regulation, WAC 284-16-600 through 284-16-650, is to establish standards and procedures for the administrative supervision of insurers exceeding their powers or engaging in methods or practices that render the continuance of their business financially hazardous to their policyholders, creditors or the general public.

[Statutory Authority: RCW 48.02.060, 48.31.435, 48.31.400, and 48.31.900. 09-23-022 (Matter No. R 2008-15), § 284-16-600, filed 11/9/09, effective 12/10/09.]

WAC 284-16-610 Definitions. The following definitions apply throughout this regulation unless the context clearly requires otherwise:

(1) The term "exceeded its powers" has the meaning set forth at RCW 48.31.020 (2)(a).

(2) The term "financially hazardous" means the standards set forth at WAC 284-16-310.

(3) "Insurer" has the meaning set forth at RCW 48.31.020(1) and 48.31.021.

(4) "Plan of correction" is an insurer's written plan to address or correct the commissioner's requirements to abate the findings and determination in the commissioner's order for administrative supervision.

[Statutory Authority: RCW 48.02.060, 48.31.435, 48.31.400, and 48.31.900. 09-23-022 (Matter No. R 2008-15), § 284-16-610, filed 11/9/09, effective 12/10/09.]

WAC 284-16-620 Process for establishing administrative supervision of an insurer. (1) The commissioner may issue an order for administrative supervision and appoint an administrative supervisor if the commissioner makes a finding that:

(a) The insurer is in a condition which makes its continued operation financially hazardous to its policyholders, creditors or the general public; or

(b) The insurer has exceeded its powers.

(2) In making a determination in subsection (1) of this section, the commissioner will consider:

(a) The conditions in RCW 48.31.020 (2)(a) to determine whether an insurer has exceeded its powers; or

(b) The findings in RCW 48.31.400(1), standards in WAC 284-16-310, and authorized actions in WAC 284-16-320(1) to determine whether an insurer is in financially hazardous condition.

[Statutory Authority: RCW 48.02.060, 48.31.435, 48.31.400, and 48.31.900. 09-23-022 (Matter No. R 2008-15), § 284-16-620, filed 11/9/09, effective 12/10/09.]

WAC 284-16-630 Plan of correction. (1) This plan of correction must include one or more of the actions under WAC 284-16-320(2), and may include one or more prohibitions contained in the order.

(2) The contents of a plan of correction must address the specific facts and circumstances that led to the order. The plan of correction must include all of the following elements necessary to fully address the list of requirements contained in the administrative supervision order:

(a) An executive summary identifying the objective goals of the plan with key implementation dates and a projected date for full statutory compliance;

(b) A background description of the insurer describing its history, ownership structure, relationships with affiliates, management structure, key employees, and overall operating structure of its organization;

(c) The financial condition of the insurer summarizing its major categories of assets and liabilities, revenues and expenses, and debt and capital structure based on actual annual results for the previous two calendar years and monthly financial forecasts and assumptions for the next three year period to include any specific business plans by function from the date of the commissioner's order;

(d) The causes of the financially hazardous condition or exceeding its powers situation giving rise to supervision proceedings;

(e) The proposed corrective actions specifically identifying operational changes, contractual changes, management changes, and internal control structure changes;

(f) A proposal for monitoring and reporting systems to provide periodic reviews of progress and comparisons of actual results with the plan of correction objectives;

(g) An agreement that the insurer will provide a copy of any notice, request, or other communication from any other regulatory authority that is received by the insurer under administrative supervision to the administrative supervisor or designee within five business days after receipt by the insurer; and

(h) Any other element necessary to fully address a requirement contained in the administrative supervision order.

[Statutory Authority: RCW 48.02.060, 48.31.435, 48.31.400, and 48.31.900. 09-23-022 (Matter No. R 2008-15), § 284-16-630, filed 11/9/09, effective 12/10/09.]

WAC 284-16-640 Compliance with written requirements of commissioner—Noncompliance. (1) Within fifteen days after receipt of the commissioner's order, the insurer under administrative supervision must submit its plan of correction to address or correct the stated requirements in writing to the commissioner. The commissioner may extend the fifteen-day time period for submission of the plan of correction if the commissioner finds the insurer establishes good cause for the extension.

(2) If the commissioner and the insurer agree on the plan of correction, the commissioner will issue a written order to carry out the plan of correction. The insurer must not implement its plan of correction prior to receiving written approval by the commissioner.

(3) If the insurer fails to timely submit or the commissioner and the insurer are unable to agree to a plan of correction, the commissioner may enter an order requiring the insurer to take such corrective actions as may be reasonably necessary to remove the causes and conditions giving rise to the need for administrative supervision.

(4) Failure of the insurer to timely submit a plan of correction is a violation of the applicable provisions of Title 48 RCW.

(5) A copy of the commissioner's order approving the plan of correction or the order requiring the insurer to take corrective actions will be provided to the insurer and to the administrative supervisor.

[Statutory Authority: RCW 48.02.060, 48.31.435, 48.31.400, and 48.31.900. 09-23-022 (Matter No. R 2008-15), § 284-16-640, filed 11/9/09, effective 12/10/09.]

WAC 284-16-650 Administrative supervisor duties. (1) To the extent possible and consistent with the list of requirements referenced in RCW 48.31.400 (2)(b), the administrative supervisor will allow the insurer to continue its existing operations.

(2) The administrative supervisor will establish appropriate disbursement limits consistent with good internal control principles to facilitate prompt payment of claims and payables.

(3) Unless the processing of claims is an issue identified in the list of requirements referenced in RCW 48.31.400 (2)(b), the administrative supervisor will allow claims to be processed in the ordinary course of business.

(4) The administrative supervisor will promptly acknowledge every insurer's request for approval of actions identified in the administrative supervision order or plan of correction that requires approval. To the extent feasible, the administrative supervisor will act on an insurer's requests within five business days after receipt.

[Statutory Authority: RCW 48.02.060, 48.31.435, 48.31.400, and 48.31.900. 09-23-022 (Matter No. R 2008-15), § 284-16-650, filed 11/9/09, effective 12/10/09.]

Chapter 284-17 WAC
LICENSING REQUIREMENTS AND PROCEDURES

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-17-121 Qualifications of agents of insurers authorized to transact more than one line of insurance—Exceptions. [Statutory Authority: RCW 48.01.030, 48.02.060(3), 48.14.010, 48.17.150(2), 48.17.160 (1)(5) and 48.17.500(3). 94-14-033 (Order R 94-14), § 284-17-121, filed 6/28/94, effective 7/29/94. Statutory Authority: RCW 48.02.060. 90-04-060 (Order R 90-1), § 284-17-121, filed 2/2/90, effective 3/5/90.] Repealed by 09-02-073 (Matter No. R 2008-06), filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.005.

284-17-228 What is required for a self-study course? [Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-228, filed 3/17/05, effective 4/17/05.] Repealed by 09-14-034 (Matter No. R-2009-03), filed 6/24/09, effective 7/25/09. Statutory Authority: RCW 48.02.060 and 48.17.150.

284-17-230 May I take any approved continuing education course? [Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-230, filed 3/17/05, effective 4/17/05. Statutory Authority: RCW 48.02.060. 89-19-037 (Order R 89-10), § 284-17-230, filed 9/15/89, effective 10/16/89. 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.] Repealed by 09-02-073 (Matter No. R 2008-06), filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.005.

284-17-232 When must I meet the continuing education requirement? [Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-232, filed 3/17/05, effective 4/17/05.] Repealed by 09-02-073 (Matter No. R 2008-06), filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.005.

284-17-234 What happens if I am late renewing my license? [Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-234, filed 3/17/05, effective 4/17/05.] Repealed by 09-02-073 (Matter No. R 2008-06), filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.005.

284-17-236 What happens if my renewal is received prior to expiration but is incomplete due to the submission of an invalid course(s), an incorrect fee or noncompletion of the renewal notice? [Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-236, filed 3/17/05, effective 4/17/05.] Repealed by 09-02-073 (Matter No. R

2008-06), filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.005.

284-17-238 What happens if I do not meet the continuing education requirement? [Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-238, filed 3/17/05, effective 4/17/05.] Repealed by 09-02-073 (Matter No. R 2008-06), filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.005.

284-17-240 Can I reinstate my license? [Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-240, filed 3/17/05, effective 4/17/05. 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.] Repealed by 09-02-073 (Matter No. R 2008-06), filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.005.

284-17-242 How long do I have to keep the course completion certificates? [Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-242, filed 3/17/05, effective 4/17/05.] Repealed by 09-02-073 (Matter No. R 2008-06), filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.005.

284-17-248 How long are my certificates of completion valid? [Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-248, filed 3/17/05, effective 4/17/05.] Repealed by 09-02-073 (Matter No. R 2008-06), filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.005.

284-17-280 What courses are eligible for approval? [Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-280, filed 3/17/05, effective 4/17/05. Statutory Authority: RCW 48.02.060. 89-19-037 (Order R 89-10), § 284-17-280, filed 9/15/89, effective 10/16/89. 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.] Repealed by 09-02-073 (Matter No. R 2008-06), filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.005.

284-17-288 What attendance records must the provider maintain? [Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-288, filed 3/17/05, effective 4/17/05.] Repealed by 09-02-073 (Matter No. R 2008-06), filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.005.

284-17-290 How long must the provider maintain the attendance or purchase and completion records? [Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-290, filed 3/17/05, effective 4/17/05. Statutory Authority: RCW 48.01.030, 48.02.060(3), 48.14.010, 48.17.150(2), 48.17.160 (1)(5) and 48.17.500(3). 94-14-033 (Order R 94-14), § 284-17-290, filed 6/28/94, effective 7/29/94. Statutory Authority: RCW 48.02.060. 89-19-037 (Order R 89-10), § 284-17-290, filed 9/15/89, effective 10/16/89. 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.] Repealed by 09-02-073 (Matter No. R 2008-06), filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.005.

284-17-298 Must I submit an electronic attendance roster? [Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-298, filed 3/17/05, effective 4/17/05.] Repealed by 09-02-073 (Matter No. R 2008-06), filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.005.

284-17-301 Does the commissioner have the authority to levy a fine against a CE provider or revoke or suspend a CE provider's approval? [Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-301, filed 3/17/05, effective 4/17/05.] Repealed by 09-02-073 (Matter No. R 2008-06), filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.005.

284-17-308 May I advertise a course prior to approval? [Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-308, filed 3/17/05, effective 4/17/05.] Repealed by 09-02-073 (Matter No. R 2008-06), filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.005.

284-17-320 What are the qualifications of an instructor? [Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-320, filed 3/17/05, effective 4/17/05. Statutory Authority: RCW 48.01.030, 48.02.060(3), 48.14.010, 48.17.150(2), 48.17.160 (1)(5) and 48.17.500(3). 94-14-033 (Order R 94-14), § 284-17-320, filed 6/28/94, effective 7/29/94. Statutory Authority: RCW 48.02.060. 89-19-037 (Order R 89-10), § 284-17-320, filed 9/15/89, effective 10/16/89. 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.] Repealed by 09-02-073 (Matter No. R 2008-06), filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.005.

284-17-421 Definitions. [Statutory Authority: RCW 48.02.060. 08-17-063 (Matter No. R 2008-03), § 284-17-421, filed 8/18/08, effective 9/18/08. Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-421, filed 5/30/06, effective 6/30/06.] Repealed by 09-02-073 (Matter No. R 2008-06), filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.005.

284-17-425 How long are initial and reinstated business entity licenses in effect? [Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-425, filed 5/30/06, effective 6/30/06.] Repealed by 09-02-073 (Matter No. R 2008-06), filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.005.

284-17-427 What is the renewal period for a license? [Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-427, filed 5/30/06, effective 6/30/06.] Repealed by 09-02-073 (Matter No. R 2008-06), filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.005.

284-17-431 What is the renewal period for an appointment? [Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-431, filed 5/30/06, effective 6/30/06.] Repealed by 09-02-073 (Matter No. R 2008-06), filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.005.

284-17-433 How long is an appointment effective? [Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-433, filed 5/30/06, effective 6/30/06.] Repealed by 09-02-073 (Matter No. R 2008-06), filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.005.

284-17-437 Appointments of agents. [Statutory Authority: RCW 48.02.060. 08-17-063 (Matter No. R 2008-03), § 284-17-437, filed 8/18/08, effective 9/18/08. Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-437, filed 5/30/06, effective 6/30/06.] Repealed by 09-02-073 (Matter No. R 2008-06), filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.005.

284-17-441 Notice to an insurer if an agent is not eligible for an appointment if the appointment was not submitted electronically. [Statutory Authority: RCW 48.02.060. 08-17-063 (Matter No. R 2008-03), § 284-17-441, filed 8/18/08, effective 9/18/08. Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-441, filed 5/30/06, effective 6/30/06.] Repealed by 09-02-073 (Matter No. R 2008-06), filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.005.

284-17-447 Termination of an appointment by an agent. [Statutory Authority: RCW 48.02.060. 08-17-063 (Matter No. R 2008-03), § 284-17-447, filed 8/18/08, effective 9/18/08. Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-447, filed 5/30/06, effective 6/30/06.] Repealed by 09-02-073 (Matter No. R 2008-06), filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.005.

284-17-455 Agent must be licensed for all lines of authority of the appointing insurer. [Statutory Authority: RCW 48.02.-060. 08-17-063 (Matter No. R 2008-03), § 284-17-455, filed 8/18/08, effective 9/18/08. Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-455, filed 5/30/06, effective 6/30/06.] Repealed by 09-02-073 (Matter No. R 2008-06), filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.005.

284-17-457 Authority of an agent to act as a representative of an insurer and solicit insurance on its behalf before notifying the commissioner of the appointment. [Statutory Authority: RCW 48.02.060. 08-17-063 (Matter No. R 2008-03), § 284-17-457, filed 8/18/08, effective 9/18/08. Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-457, filed 5/30/06, effective 6/30/06.] Repealed by 09-02-073 (Matter No. R 2008-06), filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.005.

284-17-463 Who is responsible for ensuring that the agent is eligible for appointment? [Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-463, filed 5/30/06, effective 6/30/06.] Repealed by 09-02-073 (Matter No. R 2008-06), filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.005.

284-17-469 Is the insurer responsible for the acts of the agent during the period of time the agent is acting as a representative of the insurer or soliciting insurance on its behalf? [Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-469, filed 5/30/06, effective 6/30/06.] Repealed by 09-02-073 (Matter No. R 2008-06), filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.-005.

284-17-471 What are the consequences if the commissioner is not notified of the appointment within thirty calendar days after the date the agent has signed the first application for insurance for submission to the insurer and the agent continues to act as a representative of the insurer or solicit insurance on its behalf? [Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-471, filed 5/30/06, effective 6/30/06.] Repealed by 09-02-073 (Matter No. R 2008-06), filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.005.

284-17-477 Valid period of an affiliation. [Statutory Authority: RCW 48.02.060. 08-17-063 (Matter No. R 2008-03), § 284-17-477, filed 8/18/08, effective 9/18/08. Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-477, filed 5/30/06, effective 6/30/06.] Repealed by 09-02-073 (Matter No. R 2008-06), filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.-005.

284-17-479 Termination of an affiliation by a business entity. [Statutory Authority: RCW 48.02.060. 08-17-063 (Matter No. R 2008-03), § 284-17-479, filed 8/18/08, effective 9/18/08. Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-479, filed 5/30/06, effective 6/30/06.] Repealed by 09-02-073 (Matter No. R 2008-06), filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.005.

284-17-481 Requirements for termination of an affiliation by a business entity "for cause." [Statutory Authority: RCW 48.02.060. 08-17-063 (Matter No. R 2008-03), § 284-17-481, filed 8/18/08, effective 9/18/08. Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-481, filed 5/30/06, effective 6/30/06.] Repealed by 09-02-073 (Matter No. R 2008-06), filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.-005.

284-17-482 Information to be provided relating to a "for cause" termination to the commissioner. [Statutory Authority: RCW 48.02.060. 08-17-063 (Matter No. R 2008-03), § 284-17-482, filed 8/18/08, effective 9/18/08. Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-482, filed 5/30/06, effective 6/30/06.] Repealed by 09-02-073 (Matter No. R 2008-06), filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.-005.

284-17-552 Life insurance curriculum. [Statutory Authority: RCW 48.02.060 and 48.17.150. 91-12-033 (Order R 91-3), § 284-17-552, filed 6/3/91, effective 7/4/91. Statutory Authority: RCW 48.02.060 and 48.17.070. 89-01-055 (Order R 88-14), § 284-17-552, filed 12/16/88.] Repealed by 09-02-073 (Matter No. R 2008-06), filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.005.

284-17-553 Disability insurance curriculum. [Statutory Authority: RCW 48.02.060 and 48.17.150. 91-12-033 (Order R 91-3), § 284-17-553, filed 6/3/91, effective 7/4/91. Statutory Authority: RCW 48.02.060 and 48.17.070. 89-01-055 (Order R 88-14), § 284-17-553, filed 12/16/88.] Repealed by 09-02-073 (Matter No. R 2008-06), filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.005.

284-17-554 Casualty insurance curriculum. [Statutory Authority: RCW 48.02.060 and 48.17.150. 91-12-033 (Order R 91-3), § 284-17-554, filed 6/3/91, effective 7/4/91. Statutory Authority: RCW 48.02.060 and 48.17.070. 89-01-055 (Order R 88-14), § 284-17-554, filed 12/16/88.] Repealed by 09-02-073 (Matter No. R 2008-06), filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.005.

284-17-555 Property insurance curriculum. [Statutory Authority: RCW 48.02.060 and 48.17.150. 91-12-033 (Order R 91-3), § 284-17-555, filed 6/3/91, effective 7/4/91. Statutory Authority: RCW 48.02.060 and 48.17.070. 89-01-055 (Order R 88-14), § 284-17-555, filed 12/16/88.] Repealed by 09-02-073 (Matter No. R 2008-06), filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.005.

WAC 284-17-001 Definitions. For purposes of this chapter, unless the context requires otherwise:

(1) "Affiliation" is a type of appointment whereby a business entity authorizes an individual insurance producer or surplus line broker to represent it when conducting insurance business.

(2) "Business entity" has the meaning set forth in RCW 48.17.010(2) and includes a sole proprietorship having associated licensees authorized to act on its behalf in the business or trade name of the sole proprietorship.

(3) "Days" means calendar days including Saturday and Sunday and holidays, unless otherwise specified.

(4) "File" means a record in any retrievable format, and unless otherwise specified, includes paper and electronic formats.

(5) "Home state" has the meaning set forth in RCW 48.17.010(3).

(6) "Insurer" has the meaning set forth in RCW 48.17.-010(6).

(7) "Licensee" means a person licensed by the commissioner under Title 48 RCW to sell, solicit or negotiate insurance and includes adjusters.

(8) "Line of authority" means a license issued in one or more lines of insurance listed in RCW 48.17.170.

(9) "NAIC" means the National Association of Insurance Commissioners.

(10) "Reinstatement" means the reissuance by the commissioner of a license that was not renewed more than sixty days but fewer than twelve months after its expiration date.

(11) "Resident" means a person who has elected to make Washington his or her home state, or, in the case of a business entity, has a place of business in this state.

(12) "Sending written notice" or "sending a copy of the written notice" means transmitting the required information in writing and, where required, on forms designated by the

commissioner for that purpose, via first class mail, commercial parcel delivery company, telefacsimile, or electronic transmission, unless a specific method of transmission is specified.

(13) "Surety" means that limited line of authority of insurance or bond that covers obligations to pay the debts of, or answer for the default of another, including faithlessness in a position of public or private trust.

(14) "Travel insurance" means that limited line of authority of insurance coverage for trip cancellation, trip interruption, baggage, life, sickness and accident, disability, and personal effects when limited to a specific trip and sold in connection with transportation provided by a common carrier.

(15) "Written" or "in writing" means any retrievable method of recording an agreement or document, and, unless otherwise specified, includes paper and electronic formats.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-001, filed 1/6/09, effective 7/1/09.]

WAC 284-17-005 Address of record. The address of record used by the commissioner will be the last mailing address provided by the person or entity to the commissioner.

Licensees must advise the commissioner of any change of address within thirty days after a change of address. This includes any change in the person's residence, mailing, business or e-mail address. Failure to advise the commissioner of a change of address may subject a licensee to disciplinary action under RCW 48.17.530 and 48.17.560.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-005, filed 1/6/09, effective 7/1/09.]

WAC 284-17-009 Limited line credit insurance. Limited line credit insurance is defined at RCW 48.17.010(8).

(1) Insurers must ensure that their licensed and appointed insurance producers who transact the limited line credit insurance are qualified by education or experience to offer their credit insurance products.

(2) The requirements of this chapter for prelicensing and continuing insurance education do not apply to insurance producers that transact only the limited line credit insurance.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-009, filed 1/6/09, effective 7/1/09.]

WAC 284-17-011 Limited line of travel insurance. Travel insurance is a limited line of authority and is defined in WAC 284-17-001(14).

(1) Insurers must ensure that their licensed and appointed insurance producers who transact the limited line of travel insurance are qualified by education or experience to offer their travel insurance products.

(2) The requirements of this chapter for passing an insurance producer examination and for prelicensing and continuing insurance education do not apply to insurance producers that transact only the limited line of travel insurance.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-011, filed 1/6/09, effective 7/1/09.]

WAC 284-17-015 Variable life and variable annuity products—Standards for resident licenses. (1) Resident insurance producers who desire to sell, solicit or negotiate variable life and variable annuity products in this state must obtain and maintain an insurance producer license with a life line of authority and an appropriate securities license from the Financial Industry Regulatory Authority (FINRA). Upon presentation of satisfactory evidence that the producer has fulfilled this requirement, the commissioner will issue a license with a variable life and variable annuity products line of authority.

(2) All licensees with the variable life and variable annuity products line of authority are also subject to the licensing requirements set forth in RCW 48.18A.060.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-015, filed 1/6/09, effective 7/1/09.]

WAC 284-17-120 Resident insurance producer licensees—Examination required, procedures. Prior to the transaction of insurance, an applicant for a resident insurance producer's license must take and pass the required examination for each line of authority to be applied for, submit an application form with the required attachments and fees, and receive a license from the commissioner.

(1) **Examinations.**

(a) Any resident person applying to take an examination for a license listed in this section must submit a registration form and the applicable examination fee to an independent testing service designated by the commissioner.

(i) The examination fee is not refundable.

(ii)Registration forms and information about examinations may be obtained from the commissioner or from the independent testing service under contract with the commissioner to conduct licensing examinations in this state.

(iii) An examination registration form can be downloaded through the commissioner's web site and current information about registered testing services, fees, dates, and other information is available through the commissioner's web site at www.insurance.wa.gov.

(b) The examinations required for each line of authority are identified in the following table. The independent testing service will conduct these examinations at least once each month at predetermined locations.

LINE OF AUTHORITY OR TYPE OF LICENSE	REQUIRED EXAMINATION(S)
Life	Life
Disability	Disability
Life and disability	Life and disability
Property	Property
Casualty	Casualty
Property and casualty	Property and casualty
Personal lines	Personal lines
Adjusters (independent or public)	Adjuster
Limited line credit insurance	Credit
Surety	Surety
Surplus line	Surplus line
Variable life and variable annuity products	Life

(c) If an applicant fails to take a scheduled examination, and requests to take the exam at a later date, a new examina-

tion date must be scheduled and a new examination fee must be paid, unless repayment of the fee is waived by the commissioner because the commissioner agrees that a serious emergency prevented the applicant's attendance at the scheduled date.

(d) Examinations will be graded by the independent testing service and each applicant will be provided a score report.

(2) **Application for a license.** The application for a license must be accompanied by all of the following: The score report from the testing service, a completed insurance license application, one fingerprint card and the applicable license, appointment and filing fees.

(3) **Approval by the commissioner.** The commissioner will review the application and if all requirements have been met will issue the license(s) applied for.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-120, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060. 08-17-063 (Matter No. R 2008-03), § 284-17-120, filed 8/18/08, effective 9/18/08. Statutory Authority: RCW 48.01.030, 48.02.060(3), 48.14.010, 48.17.150(2), 48.17.160 (1)(5) and 48.17.500(3). 94-14-033 (Order R 94-14), § 284-17-120, filed 6/28/94, effective 7/29/94. Statutory Authority: RCW 48.02.060. 88-24-054 (Order R 88-13), § 284-17-120, filed 12/7/88; 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 284-17-122 Applications for nonresident licenses. (1) Applicants who are not residents of Washington may be licensed as nonresident insurance producers without taking the required Washington examinations specified in WAC 284-17-120 (1)(b) if:

(a) The applicant has and maintains in good standing a similar license in his or her home state for the applicable line(s) of authority defined in RCW 48.17.170; and

(b) The home state reciprocates and licenses Washington's insurance producers as nonresident insurance producers.

(2) Nonresident applicants whose home state requires submission of a fingerprint card for conducting background checks in connection with resident insurance producer (or equivalent) license, need not provide a fingerprint card to the commissioner.

(a) A list of states that the commissioner believes require a fingerprint card will be available on the commissioner's web site at www.insurance.wa.gov.

(b) If the home state of an applicant does not appear on that list and the applicant believes that list should include his or her home state, the applicant may provide information concerning the requirements of his or her home state for the commissioner's review. The commissioner will consider that information and determine whether the applicant's home state should be added to that list.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-122, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060. 90-04-060 (Order R 90-1), § 284-17-122, filed 2/2/90, effective 3/5/90.]

WAC 284-17-123 Resident and nonresident adjuster licenses—Trainees. (1) Applicants for a resident adjuster license may satisfy the experience or special training requirements of RCW 48.17.380(4) by employment as a "trainee" for a period of not fewer than six months.

(a) Each trainee must be supervised by a resident licensed adjuster. Trainees must receive training in all adjustment activities and responsibilities. Activities of the trainee must be restricted to participation in factual investigation and tentative closing of losses. All adjusting transactions must be completed in the name of the supervising licensed adjuster who must review, confirm, and be responsible for all acts of the trainee. Compensation of a trainee must be on a salary basis only.

(b) Any person employing trainees must immediately advise the commissioner and provide the exact date that employment of the trainee begins and ends. The employer must submit an application completed by each trainee and one fingerprint card.

(c) Trainees are eligible to take the adjuster's examination required by the commissioner after completing no fewer than six months as a trainee.

(d) The maximum period a person may be designated as a trainee is one nine-month period.

(e) Any violation of this section or a violation of any provision of the insurance code subjects both the trainee and the supervisory adjuster to penalties of the code.

(2) Applicants who are not residents of Washington may be licensed as nonresident adjusters as follows:

(a) A nonresident adjuster license will be issued if the applicant has and maintains an adjuster license in good standing in his or her home state and the home state reciprocates and licenses Washington adjusters as nonresident adjusters.

(b) If the home state of an applicant for an adjuster license does not issue an adjuster license, the applicant must pass this state's written adjuster examination.

(c) If the home state of an applicant for a nonresident adjuster license does not issue an adjuster license but he or she has an active adjuster license as a nonresident in a state other than Washington that requires passing an examination, and he or she has taken and passed the examination and is in good standing with that state, the nonresident adjuster is deemed by the commissioner to have satisfied the examination required for adjusters in this state.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-123, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060. 90-04-060 (Order R 90-1), § 284-17-123, filed 2/2/90, effective 3/5/90.]

WAC 284-17-124 Examination for limited line surety and limited line credit insurance license required. Applicants for a limited line surety or limited line credit insurance license must take and pass the appropriate license examination. Information regarding the surety and credit insurance license examinations is available on the insurance commissioner's web site at www.insurance.wa.gov.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-124, filed 1/6/09, effective 7/1/09.]

WAC 284-17-125 Prohibited acts or practices by license examinees. In addition to the unlawful acts set forth in RCW 48.17.125, the following are prohibited acts or practices by persons taking examinations for licenses:

(1) Behavior that undermines the evaluative objective of the examination;

(2) Communication with any other examinee during the examination period;

(3) Copying answers or allowing another to copy answers;

(4) Possessing during the examination any books, materials, notes, or photography or recording devices not issued or approved by the independent testing service representative; or

(5) Impersonating, or engaging another to impersonate, any applicant for the purpose of completing the examination on behalf of another.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-125, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060. 88-23-063 (Order R 88-11), § 284-17-125, filed 11/16/88.]

WAC 284-17-130 Admittance to examination. As a prerequisite to admittance to any examination designed to test the applicant's qualifications to be an insurance licensee, each applicant must certify on the form provided, that he or she:

(1) Is not taking the examination for purposes other than as the means to qualify for a license;

(2) Has not passed the examination for that line of authority within the last twelve months;

(3) Has been advised that the performance of any of the acts prohibited by WAC 284-17-125 is a violation of RCW 48.17.530 and subjects the person to disciplinary action, including refusal to issue a license, revocation of any license issued by the commissioner that is currently held by the licensee, and the imposition of a fine; and

(4) Has been advised that the unauthorized appropriation or conversion of questions or materials comprising the examination for a Washington state insurance license is a violation of federal copyright law.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-130, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060. 88-23-063 (Order R 88-11), § 284-17-130, filed 11/16/88.]

WAC 284-17-175 Education referrals. No person may accept any rebate, refund, fee, commission, or discount in connection with referrals of students to an insurance education prelicense or continuing insurance education provider without making a full disclosure to each student so referred.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-175, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060 and 48.17.070. 89-01-055 (Order R 88-14), § 284-17-175, filed 12/16/88.]

WAC 284-17-200 Continuing insurance education—Minimum standards. WAC 284-17-200 through 284-17-312 establish the minimum continuing education requirements that must be met prior to the renewal of an insurance producer license, and specify the minimum criteria that continuing insurance education courses must meet to be approved by the commissioner.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-200, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-200, filed 3/17/05, effective 4/17/05. Statutory Authority: RCW 48.02.060. 89-19-037 (Order R 89-10), § 284-17-200, filed 9/15/89, effective 10/16/89. 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. The following definitions apply to WAC 284-17-200 through 284-17-312, unless the context clearly requires otherwise:

(1) "Approved course" means a program of continuing insurance education, including live presentations, correspondence courses and seminars, formally approved by the commissioner.

(2) "Credit hour" means the value assigned to a course by the commissioner. Generally, fifty minutes of instruction equals one credit hour.

(3) "Certificate of completion" means a document signed by an authorized designee of the insurance education provider attesting to the satisfactory completion of the course and confirming the credit hours earned.

(4) "Course number" means the identifying number assigned by the commissioner to an approved insurance education course.

(5) "Course outline" means a summary of the insurance education course content, including the time allotted to each topic.

(6) "Designation course" means a course of study taken to achieve an insurance professional certification, requiring passage of several standardized examinations, and granted by an insurance or professional organization or an accredited educational institution.

(7) "Instructor" means an individual knowledgeable in topic(s) of instruction who has been designated by the insurance education provider to teach an approved course or courses.

(8) "Monitor" means the individual responsible for verifying class attendance and course completion.

(9) "Provider" or "insurance education provider" means any insurer, health care service contractor, health maintenance organization, professional association, educational institution, vocational school, or independent contractor authorized by the commissioner to conduct and certify completion of insurance education courses.

(10) "Provider number" means the identifying number assigned by the commissioner to an approved insurance education provider.

(11) "Request for approval," depending on the context, means either a request for authority to act as an insurance education provider or for approval of an insurance education course.

(12) "Roster" means a course attendance record, a record of a self-study course purchase, or a course completion record maintained by the insurance education provider.

(13) "Waiver" means an approved exemption from this state's continuing insurance education requirement granted by the commissioner.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-210, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-210, filed 3/17/05, effective 4/17/05. Statutory Authority: RCW 48.02.060. 89-19-037 (Order R 89-10), § 284-17-210, filed 9/15/89, effective 10/16/89; 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 insurance education required—Resident licensees. Except as provided in WAC 284-17-222 or waived in accordance with WAC 284-17-254,

all individual residents licensed to transact life, disability, personal lines, property, casualty or variable life and variable annuity products lines of authority must meet the continuing insurance education requirements of this chapter.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-220, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060 and 48.17.150. 08-07-102 (Matter No. R 2007-16), § 284-17-220, filed 3/19/08, effective 4/19/08; 06-23-105 (Matter No. R 2006-07), § 284-17-220, filed 11/16/06, effective 12/17/06. Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-220, filed 3/17/05, effective 4/17/05. Statutory Authority: RCW 48.02.060 and 48.17.150. 98-11-090 (Matter No. R 98-9), § 284-17-220, filed 5/20/98, effective 6/20/98. Statutory Authority: RCW 48.02.060, 48.17.150 and 48.85.030. 97-19-007, § 284-17-220, filed 9/4/97, effective 10/5/97. Statutory Authority: RCW 48.02.060, 48.17.150, 48.20.450, 48.85.030 and 48.85.040. 96-17-029 (Matter No. R 95-16), § 284-17-220, filed 8/13/96, effective 9/13/96. Statutory Authority: RCW 48.01.030, 48.02.060(3), 48.14.010, 48.17.150(2), 48.17.160 (1)(5) and 48.17.500(3). 94-14-033 (Order R 94-14), § 284-17-220, filed 6/28/94, effective 7/29/94. Statutory Authority: RCW 48.02.060. 89-19-037 (Order R 89-10), § 284-17-220, filed 9/15/89, effective 10/16/89. 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 284-17-222 Continuing insurance education exemptions. Resident adjusters and individuals holding only limited credit insurance, travel insurance, or surety licenses are exempt from the continuing insurance education requirements of this chapter.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-222, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060 and 48.17.150. 08-07-102 (Matter No. R 2007-16), § 284-17-222, filed 3/19/08, effective 4/19/08. Statutory Authority: RCW 48.02.-060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-222, filed 3/17/05, effective 4/17/05.]

WAC 284-17-224 Continuing insurance education—Required credit hours. Timely completion of this state's continuing insurance education requirement is a prerequisite for renewal or reinstatement of a license. Before applying for renewal or reinstatement of a license, except as provided in WAC 284-17-222 or waived in accordance with WAC 284-17-254, all resident persons licensed for personal lines, life, disability, property, casualty or variable life and variable annuity product lines of authority must complete twenty-four credit hours of approved continuing insurance education. The twenty-four hours of education must include three credit hours of ethics education during every license continuation period. Courses must be completed within the twenty-four month period prior to the date of renewal or the date of the request for reinstatement.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-224, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-224, filed 3/17/05, effective 4/17/05.]

WAC 284-17-226 Required proof of completion of a course. The insurance education provider must issue a certificate of completion to each attendee within ten days after completion of the course.

(1) The certificate of completion must be in the commissioner's designated format, completed in its entirety, and include all of the information prescribed by the commissioner. A form of certificate of completion is available to insurance education providers only on the commissioner's web site at www.insurance.wa.gov.

(2) For designation courses, the passing grade report will be accepted by the commissioner in lieu of a certificate of completion.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-226, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-226, filed 3/17/05, effective 4/17/05.]

WAC 284-17-244 Request for approval of attendance at an insurance related education course that is not preapproved and is given by a nonapproved insurance education provider. A licensee may request credit for completion of an insurance related course organized and conducted by an entity that is not already approved by the commissioner as a continuing insurance education provider. The commissioner will consider the educational value of the course. Evidence of the following must be provided with the licensee's request for this approval:

(1) Proof of attendance, including the signature of the instructor(s) or person in charge verifying attendance;

(2) Supporting materials in sufficient detail to show the course content; and

(3) The number of hours of actual attendance.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-244, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-244, filed 3/17/05, effective 4/17/05.]

WAC 284-17-246 Approval of continuing insurance education credit for insurance related college courses. The commissioner may grant continuing insurance education credits earned for insurance related college level courses on approved subjects. To request approval, the licensee must submit to the commissioner a copy of the course syllabus and a transcript showing that the requester completed the course. The number of credit hours will be determined as follows:

(1) Twelve hours will be assigned for each college quarter credit hour; and

(2) Sixteen hours will be assigned for each college semester credit hour.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-246, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-246, filed 3/17/05, effective 4/17/05.]

WAC 284-17-250 Retaking a continuing insurance education course. A continuing insurance education course with the same course number may be completed for credit only once every three years.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-250, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-250, filed 3/17/05, effective 4/17/05. Statutory Authority: RCW 48.01.030, 48.02.060(3), 48.14.010, 48.17.150(2), 48.17.160 (1)(5) and 48.17.500(3). 94-14-033 (Order R 94-14), § 284-17-250, filed 6/28/94, effective 7/29/94. Statutory Authority: RCW 48.02.060. 89-19-037 (Order R 89-10), § 284-17-250, filed 9/15/89, effective 10/16/89. 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 284-17-252 No carry-over of excess continuing education credits. Credit hours earned during any license continuation period in excess of the continuing insurance education requirement cannot be carried over to the next license renewal period.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-252, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-252, filed 3/17/05, effective 4/17/05.]

WAC 284-17-254 Waiver of the continuing insurance education requirements. Licensees may request a waiver of the continuing insurance education requirement. Requests must be sent to the commissioner at time of renewal of the license and must specify in detail the reason why a waiver is merited.

(1) **Medical waiver.** If the request for a waiver is based on the medical condition of the licensee, the request must be accompanied by a statement from the treating provider describing the illness or injury.

(2) **Military waiver.** If the request for a waiver is based on activation to military service, the request must be accompanied by a copy of the licensee's "Letter of Mobilization."

(a) The licensee must designate a representative (including the name and address of the individual given power-of-attorney by the licensee), by name and address, to whom the license renewal notice or other correspondence can be sent during the licensee's active military service.

(i) The address of the designee may be a mailing address or may be an e-mail address.

(ii) It is the obligation of the licensee to notify the commissioner of any change to the identity or contact information of the designee.

(b) In order to renew a license during the licensee's military deployment, the designated representative must sign the renewal form and submit it with the applicable fees to the commissioner no later than the due date.

(c) The commissioner may waive the continuing insurance education requirement for renewal of a license for the duration of the licensee's active military service.

(3) A waiver is only valid for the associated license continuation period. If the medical condition or period of active duty exists on the date of the next license renewal, a new waiver may be requested by the licensee or the licensee's designee.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-254, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-254, filed 3/17/05, effective 4/17/05.]

WAC 284-17-256 Approved credits for insurance education instructors. Instructors who teach an entire course receive twice the number of approved credit hours for that course. Credit hours for the same course may be used only once in a three-year period.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-256, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-256, filed 3/17/05, effective 4/17/05.]

WAC 284-17-270 Continuing insurance education providers—Standards. A person who seeks to become a continuing insurance education provider must meet the requirements of RCW 48.17.563 and submit the proper application for approval to act as a continuing insurance education provider. The application form can be found on the commissioner's web site at www.insurance.wa.gov.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-270, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-270, filed 3/17/05, effective 4/17/05. Statutory Authority: RCW 48.02.060. 89-19-037 (Order R 89-10), § 284-17-270, filed 9/15/89, effective 10/16/89. 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 284-17-272 Responsibilities of an approved continuing insurance education provider. (1) In addition to meeting the relevant requirements of this chapter and any other applicable law or rule, an approved continuing insurance education provider must:

(a) Provide the name of a contact person who is the responsible person for the provider;

(b) Hire only instructors who are trustworthy, competent, and knowledgeable;

(c) Provide adequate supervision over instructors;

(d) Notify the commissioner of the course schedule at least ten days prior to the course start date in the format required by the commissioner;

(e) Designate a monitor who is responsible for verification of class attendance and course content completion;

(f) Maintain a course roster, consisting of sign-in and sign-out registers, for lecture (classroom) courses;

(g) Maintain a purchase and completion roster for self-study courses;

(h) File the course roster electronically in the format required by the commissioner, within ten days after completion of the course;

(i) Issue course completion certificates to attendees within ten days after completion of course; and

(j) Maintain records for a period of three years after the completion date of the course.

(2) The format for providing this information is available on the commissioner's web site at www.insurance.wa.gov.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-272, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-272, filed 3/17/05, effective 4/17/05.]

WAC 284-17-274 Fee. No fee is required for applying to become a continuing insurance education provider or for requesting the commissioner's approval of a continuing insurance education course.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-274, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-274, filed 3/17/05, effective 4/17/05.]

WAC 284-17-276 Continuing insurance education provider numbers. A continuing insurance education provider will be assigned a provider number by the commissioner. That number must be included on all correspondence related to continuing insurance education and on all certificates of completion.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-276, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-276, filed 3/17/05, effective 4/17/05.]

WAC 284-17-278 Approval of a continuing insurance education course. (1) Requests for approval of a continuing insurance education course must be submitted to the commissioner no fewer than twenty days prior to the first date the course is offered for credit. The request must include all of the following, as applicable:

(a) **Lecture (classroom) courses:**

(i) Completed course approval request form;

(ii) Content outline, including a list of topics to be covered and an estimate of the time to be spent on each topic;

(iii) Biography or resume of instructor(s); and

(iv) Date(s) that course will be offered.

(b) **Self-study courses:**

(i) Completed course approval request form;

(ii) Study material; and

(iii) Sample exams.

(2) Continuing insurance education courses eligible for approval to satisfy the continuing insurance education requirement include:

(a) Courses demonstrating a direct and specific application to insurance; and

(b) Courses presenting information relevant to insurance-related statutory and regulatory requirements.

(3) General education, sales, motivation, management, leadership, and automation courses are not eligible unless the insurance education provider demonstrates to the satisfaction of the commissioner that a substantial portion of the course relates to the business of insurance and is not solely focused on a particular insurer's products.

(4) Prelicensing insurance education courses are not eligible for approval for continuing insurance education credit.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-278, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-278, filed 3/17/05, effective 4/17/05.]

WAC 284-17-282 Continuing insurance education course numbers. The course number issued by the commissioner at the time of approval of the continuing insurance education course must be included on all correspondence related to the course and must be included on all certificates of completion for that course.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-282, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-282, filed 3/17/05, effective 4/17/05.]

WAC 284-17-284 Designation courses. (1) Successful completion of any part of a course of study leading to an insurance professional designation is approved for the maximum number of credit hours required per renewal period as a designation course, as defined in WAC 284-17-210(6).

(2) A current list of approved designations for course credit can be found on the commissioner's web site at www.insurance.wa.gov.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-284, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-284, filed 3/17/05, effective 4/17/05.]

WAC 284-17-286 Continuing insurance education course credit hours. (1) The number of credit hours assigned to a continuing insurance education course will be based upon the number of classroom hours or the equivalent for self-study courses.

(2) After evaluation of the content of a continuing insurance education course, the commissioner may assign fewer credits than the total hours spent by the licensee in the classroom or in self-study.

(3) No continuing insurance education course will be approved for less than one hour of continuing insurance education credit.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-286, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-286, filed 3/17/05, effective 4/17/05.]

WAC 284-17-292 Certificates of completion of continuing insurance education courses—Form. The form of certificate of course completion required by the commissioner is available to insurance education providers only on the commissioner's web site at www.insurance.wa.gov. The certificate and signature may be in electronic format. The certificate must include the following:

(1) Name of student;

(2) Course title and number;

(3) Date of purchase of course, if applicable;

(4) Date of completion of course;

(5) Number of credit hours;

(6) Provider's name and number; and

(7) Signature of instructor or monitor and date.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-292, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-292, filed 3/17/05, effective 4/17/05.]

WAC 284-17-294 Renewal—Continuing insurance education provider. A continuing insurance education provider is required to request renewal of approval to act as a continuing insurance education provider only if the provider did not receive approval from the commissioner for at least one course within the last four years. Otherwise, the commissioner's approval is continuous.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-294, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-294, filed 3/17/05, effective 4/17/05.]

WAC 284-17-296 Renewal—Approval of a continuing insurance education course. Approval of a continuing insurance education course offered by an approved insurance education provider must be renewed every two years. A notice of renewal of course approval will be sent to the continuing insurance education provider. If substantive changes have been made in the course curriculum since its most recent approval, the course must be resubmitted as a new course.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-296, filed 1/6/09, effective 7/1/09. Statutory Authority:

RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-296, filed 3/17/05, effective 4/17/05.]

WAC 284-17-302 Actions by a continuing insurance education provider that may result in a fine. The following actions by a continuing insurance education provider may result in a fine:

(1) Advertising or offering a course for credit without the prior approval of the commissioner;

(2) Failing to follow the approved course outline;

(3) Issuing fraudulent completion certificates;

(4) Erroneous advertising; or

(5) Failing to comply with any statute or rule pertaining to continuing insurance education providers.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-302, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-302, filed 3/17/05, effective 4/17/05.]

WAC 284-17-304 Revocation or suspension of approval of a continuing insurance education provider—Reinstatement. (1) The commissioner's approval of a person to act as a continuing insurance education provider and approval of any or all of the provider's approved courses may be suspended or revoked by the commissioner if:

(a) The provider or any of its employees involved in continuing insurance education is found to have violated any provision of Titles 48 RCW or 284 WAC; or

(b) The commissioner finds that disciplinary action against a continuing insurance education provider is appropriate based on the facts and circumstances of the violation.

(2) Reinstatement of a suspended or revoked approval may be made by the commissioner only after acceptance of satisfactory proof that the conditions responsible for the suspension or revocation have been successfully corrected and the possibility of reoccurrence of the violation has been eliminated.

(3) Reinstatement is at the sole discretion of the commissioner.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-304, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-304, filed 3/17/05, effective 4/17/05.]

WAC 284-17-306 Grounds for revocation or suspension of approval of a continuing insurance education course. (1) Approval of a continuing insurance education course may be suspended or revoked if the commissioner concludes that any of the following has occurred:

(a) The content of an approved course is significantly changed without notice to and prior approval from the commissioner;

(b) A certificate of completion is issued to a person who did not complete the course;

(c) A certificate of completion is not issued to a person who satisfactorily completed the course;

(d) The actual instruction of the course is found by the commissioner to be inadequate; or

(e) Within fifteen days after the date of the commissioner's request, the continuing insurance education provider fails to supply updated descriptions of any course, records, materials, or audit reports.

(2) Reinstatement of approval is at the sole discretion of the commissioner and is conditioned upon receipt of satisfactory proof that the conditions responsible for the suspension have been corrected and the possibility of reoccurrence of the violation has been eliminated.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-306, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-306, filed 3/17/05, effective 4/17/05.]

WAC 284-17-310 Content of a course advertisements. A continuing insurance education course advertisement must include all of the following:

(1) The insurance education provider's name, using the name registered with the commissioner;

(2) The course title, as approved by the commissioner;

(3) A brief description of the content of the course;

(4) The number of credit hours approved by the commissioner;

(5) The location where the course will be held;

(6) The date and time that the course will be presented; and

(7) The total cost of the course.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-310, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-310, filed 3/17/05, effective 4/17/05. Statutory Authority: RCW 48.02.060. 89-19-037 (Order R 89-10), § 284-17-310, filed 9/15/89, effective 10/16/89; 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 284-17-312 NAIC Uniform continuing education reciprocity agreement. Washington participates in the NAIC Uniform Continuing Education Reciprocity Agreement. Generally, a continuing insurance education course approved by a participating state will be accepted by this state by submitting the NAIC Uniform Continuing Education Reciprocity Course filing form and any required attachments.

(1) An insurance education provider must be qualified as an approved provider in this state.

(2) A standard course filing form, available on the commissioner's web site or through the NAIC, will be acceptable for reciprocity filings.

(3) Participation in the NAIC Uniform Continuing Education Reciprocity Agreement does not change this state's standards for insurance education providers.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-312, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-312, filed 3/17/05, effective 4/17/05.]

WAC 284-17-422 Reciprocity for nonresident insurance producers holding licenses for lines of authority in the home state that are not issued in this state. If an otherwise qualified applicant for a nonresident insurance producer's license holds a license in his or her home state that is not among the recognized lines of authority in this state, the commissioner will issue a nonresident license that is substantially equivalent to the license issued by the person's home state insurance regulator.

The nonresident licensee's authority to transact insurance in this state is limited to the scope of the license granted by the licensee's home state.

For example nonresident insurance producers holding a limited line crop insurance license in their home states will be issued Washington insurance producer licenses with a property line of authority.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-422, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060. 08-17-063 (Matter No. R 2008-03), § 284-17-422, filed 8/18/08, effective 9/18/08.]

WAC 284-17-423 Term of initial and reinstated individual license. (1) Initial and reinstated individual licenses are valid from their date of issuance until the date of the licensee's next birthday anniversary plus one year. Additional licenses issued to the same active licensee will be on the same renewal cycle as the first license issued to that licensee.

(2) The renewal date of a business entity license is based on the date of application. The license is valid for two years. Additional licenses issued to the same active licensee will be on the same renewal cycle as the first license issued to that licensee.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-423, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-423, filed 5/30/06, effective 6/30/06.]

WAC 284-17-429 Appointments and affiliations of licensees. (1) An insurance producer may be appointed or affiliated:

(a) By submitting the notice of appointment or affiliation electronically through a third-party on-line licensing provider or the commissioner's on-line services, available at www.insurance.wa.gov; or

(b) By submitting the notice of appointment or affiliation to the commissioner using the form provided by the commissioner for that purpose available on the commissioner's web site at www.insurance.wa.gov.

(2) Insurance producers upon initial appointment by an insurer or upon initial affiliation by a business entity must be authorized to transact at least one line of authority within the authority of the insurer or the business entity.

(3) Initial appointments and affiliations are continuous. Each appointment or affiliation is effective until the insurance producer's license is revoked, terminated, or nonrenewed; the appointment or affiliation renewal fee is not paid; or written notice of termination is received by the commissioner, whichever occurs first.

(4) The insurer is obligated to ensure that its appointed insurance producers are licensed for the proper line of authority for which the insurance producer submits an application for insurance.

(5) Individual surplus line brokers may be affiliated with a business entity possessing a surplus line broker license in the manner set forth in subsection (1) of this section.

(6) Business entities are obligated to ensure that all affiliated insurance producers for the proper line of authority for which the insurance producer submits an application for insurance and that surplus line brokers are properly licensed.

(7) The applicable initial and renewal appointment and affiliation fees, as set forth in RCW 48.14.010, must be paid at the time of appointment, affiliation, or their renewals.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-429, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-429, filed 5/30/06, effective 6/30/06.]

WAC 284-17-435 Notification of appointments and affiliations. The commissioner will confirm the licensee's appointment or affiliation by sending an electronic message to the insurer or business entity within fifteen days after the commissioner receives the notice from an insurer or business entity. If an insurer or business entity is not registered with the commissioner's on-line services, notice will be sent to the address of record.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-435, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-435, filed 5/30/06, effective 6/30/06.]

WAC 284-17-439 Notice that a licensee is not eligible for an electronic appointment or affiliation. A licensee is not eligible for an appointment or affiliation if the license is not valid or the person is not licensed for at least one line of authority within the authority of the appointing insurer or affiliating business entity. If a licensee is not eligible for an electronic appointment or affiliation, the insurer or business entity will be notified at the time the electronic notice of appointment or affiliation is not accepted for transmission through the third-party on-line licensing provider or the commissioner's web site.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-439, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060. 08-17-063 (Matter No. R 2008-03), § 284-17-439, filed 8/18/08, effective 9/18/08. Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-439, filed 5/30/06, effective 6/30/06.]

WAC 284-17-443 Renewal fee for an appointment or affiliation. (1) **Insurer and business entities that are not registered with the commissioner's on-line services.**

(a) At least forty-five days prior to the renewal date, an appointment or affiliation list will be sent to the insurer or business entity identifying all of the licensees appointed by or affiliated with the insurer or business entity whose appointments or affiliations are due to expire.

(b) The insurer or business entity must verify that the list is accurate, make any changes, and return the list with the correct fees to the commissioner.

(c) The verified and corrected list and fees are due to the commissioner no later than the renewal date.

(2) **Insurer and business entities that are registered with the commissioner's on-line services.**

(a) At least sixty days prior to the renewal date, an appointment or affiliation renewal fee notice will be sent to the insurer or business entity electronically.

(b) The insurer or business entity may review the on-line list of appointees or affiliates, make any changes and must remit the correct fees to the commissioner.

(c) The on-line appointment or affiliation renewal and payment of fees must be completed no later than the renewal date.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-443, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060. 08-17-063 (Matter No. R 2008-03), § 284-17-443, filed 8/18/08, effective 9/18/08. Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-443, filed 5/30/06, effective 6/30/06.]

WAC 284-17-445 Termination of an appointment or affiliation by an insurer or business entity. (1) An insurer or business entity may terminate an appointment or affiliation of an insurance producer or surplus line broker through the commissioner's web site if the insurer or business entity is registered for on-line services by sending written notice of termination to the insurance producer or surplus line broker with a copy to the commissioner, or through a third-party on-line licensing provider. A form for that purpose is available on the commissioner's web site at www.insurance.wa.gov.

(2) The effective date of the termination is the date of receipt by the commissioner.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-445, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060. 08-17-063 (Matter No. R 2008-03), § 284-17-445, filed 8/18/08, effective 9/18/08. Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-445, filed 5/30/06, effective 6/30/06.]

WAC 284-17-449 Termination of an affiliation for cause. If a business entity or its authorized representative terminates the affiliation of an insurance producer or surplus line broker for cause, the commissioner must receive notice of that termination by mail or electronic facsimile within thirty days following the effective date of the termination.

(1) A form for this purpose is available on the commissioner's web site at www.insurance.wa.gov.

(2) Upon the request of the commissioner, additional information, documents, records or other data pertaining to the for-cause termination or activity of a licensee's affiliation must be provided promptly to the commissioner.

(3) The reasons an insurance producer may be terminated for cause are set forth in RCW 48.17.530 and 48.17.595. The reasons a surplus line broker may be terminated for cause are set forth in RCW 48.15.140.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-449, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060. 08-17-063 (Matter No. R 2008-03), § 284-17-449, filed 8/18/08, effective 9/18/08. Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-449, filed 5/30/06, effective 6/30/06.]

WAC 284-17-467 Consequences—Insurance producers not eligible for appointment by the insurer. If an insurance producer solicits insurance on behalf of an insurer, as authorized by RCW 48.17.160, but it is later determined that the insurance producer was not eligible for appointment by the insurer:

(1) The insurance contract will be effective;

(2) The insurance producer must not receive compensation for any insurance product sold by the insurance producer; and

(3) The insurance producer and the insurer may be subject to disciplinary action under RCW 48.17.530.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-467, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060. 08-17-063 (Matter No. R 2008-03), § 284-17-467, filed 8/18/08, effective 9/18/08. Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-467, filed 5/30/06, effective 6/30/06.]

WAC 284-17-473 Affiliation requirements. Individual licensees that represent a business entity or act on its behalf must be affiliated with the licensed business entity. A business entity must have at least one affiliated individual licensee in order to transact insurance business. Each business entity must provide the commissioner with the names of all individual licensees authorized to represent the business entity and act on its behalf using the form provided by the commissioner for that purpose and paying the applicable fees, or by using the on-line services available through the commissioner's web site at www.insurance.wa.gov.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-473, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060. 08-17-063 (Matter No. R 2008-03), § 284-17-473, filed 8/18/08, effective 9/18/08. Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-473, filed 5/30/06, effective 6/30/06.]

WAC 284-17-476 License requirements for business entity affiliations. If an individual insurance producer is affiliated with a business entity, the insurance producer is not required to be directly appointed by the insurer.

(1) The individual insurance producer's authority to transact insurance is limited to those lines of authority for which the insurance producer is licensed and that are within the business entity's lines of authority.

(2) When an insurance producer places business with an insurer that has appointed the business entity with which the insurance producer is affiliated, the insurance producer is deemed to be placing business with an insurer with which the insurance producer holds an appointment for the purpose of the bonding requirements set out in RCW 48.17.250.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-476, filed 1/6/09, effective 7/1/09.]

WAC 284-17-483 Termination of an appointment or affiliation by an insurance producer. (1) An insurance producer or surplus line broker may terminate its appointment or affiliation with an insurer or business entity by sending advance written notice to the insurer or business entity, with a copy to the commissioner.

(2) The notice must state that the insurance producer or surplus line broker will no longer transact insurance on behalf of the business entity, as the case may be.

(3) The effective date of the termination is the date of receipt by the commissioner.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-483, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060. 08-17-063 (Matter No. R 2008-03), § 284-17-483, filed 8/18/08, effective 9/18/08. Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-483, filed 5/30/06, effective 6/30/06.]

WAC 284-17-490 Late renewal or reinstatement. If a request for renewal of a license is received by the commissioner after its due date, the licensee must not transact insurance under the license until the renewal or reinstatement is completed.

(1) As a precondition to late renewal or reinstatement of a license, payment of the following late fees, as set forth in RCW 48.17.170 (6) and (7), is required:

Days Late	Surcharge
First 30 days late	50% of the license renewal fee
31-60 days late	100% of the license renewal fee
61 days to twelve months late	200% of the license renewal fee

(2) If no request for late renewal is received by the commissioner within sixty days after expiration of a license, the license and all associated appointments and affiliations will be terminated. All authority conferred by the license ends on its expiration date.

(3) If a license is expired for more than sixty days but less than twelve months, a licensee may request its reinstatement. A license is not eligible for reinstatement if the reinstatement application is received by the commissioner more than twelve months after its expiration date.

(4)(a) A licensee may request reinstatement of a license without retesting if no more than twelve months has passed since the expiration or cancellation date of the license, whichever is earlier. All of the following must accompany the request for reinstatement:

(i) A completed application for reinstatement;

(ii) Certificates for twenty-four credit hours of continuing insurance education, including three hours of ethics education, completed during the twenty-four months prior to the date of application for reinstatement, as set forth in WAC 284-17-224; and

(iii) The fee and surcharge applicable to the reinstatement, as set forth in subsection (1) of this section.

(b) After twelve months, the licensee must retake and pass all applicable prelicensing insurance education courses and the applicable license examinations. A new license application, including fingerprint card, and all required fees are also required. A new fingerprint card is not required if the licensee has other active licenses or held another license during the past year.

(5)(a) If a licensee cancels a license prior to its renewal date and later asks that it be reissued and the request to reissue is submitted prior to the license renewal date, the licensee must submit an application and must pay the applicable fee prior to the license renewal date.

(b) If a licensee cancels a license prior to its renewal date and a request to reissue the license is made after the license renewal date but before twelve months after the date the license was canceled, the request to reissue will be treated as though it were a late renewal or reinstatement and the late fee will be calculated from the cancellation date.

(c) If the request to reissue is made more than twelve months after the license renewal date, it cannot be reissued.

(d) The renewal date of any reissued license will be on the same renewal cycle as the original license.

(6) Information regarding renewal or reinstatement of a license and the necessary forms are available at the commissioner's web site at www.insurance.wa.gov.

(7) License renewals and reinstatements may be submitted by licensees that are registered with the commissioner's on-line services through the web site at www.insurance.wa.gov.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-490, filed 1/6/09, effective 7/1/09.]

WAC 284-17-505 Definitions. As used in WAC 284-17-505 through 284-17-580, the terms below have the following meaning unless the context clearly requires otherwise:

(1) "Approved prelicensing insurance education provider" means a provider to which the commissioner has granted authority to conduct and certify completion of an approved course satisfying the prelicensing insurance education requirements of this state.

(2) "Approved course" means a series of seminars, classes, or lectures meeting the requirements of WAC 284-17-517 and 284-17-550, covering the prescribed course of study. A course is approved only if when offered it will be supervised by an approved program director, and presented by or under the supervision of an approved instructor, according to the applicable section of either WAC 284-17-540 or 284-17-545.

(3) "Instructor" means a person meeting the requirements of WAC 284-17-537.

(4) "Curriculum" means the course of study prescribed for prelicensing insurance education by the commissioner, covering personal lines, life, disability, property or casualty lines of authority, and Washington insurance laws and rules.

(5) "Independent testing service" means the entity having a contract with the commissioner to develop, administer, and score prelicensing insurance examinations.

(6) "Independent provider" means an insurance education provider that is not an insurer or affiliated with an insurer.

(7) "Provider" or "prelicensing insurance education provider" means any insurer, health care service contractor, health maintenance organization, professional association, educational institution, vocational school, or independent contractor authorized by the commissioner to conduct and certify completion of prelicensing insurance education courses.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-505, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060. 89-14-045 (Order R 89-8), § 284-17-505, filed 6/29/89. Statutory Authority: RCW 48.02.060 and 48.17.070. 89-01-055 (Order R 88-14), § 284-17-505, filed 12/16/88.]

WAC 284-17-510 Prelicensing insurance education requirement. (1) Unless waived by the commissioner under WAC 284-17-515, as a prerequisite to admission to the examination, an applicant for a resident insurance producer license for personal lines, life, disability, property or casualty line of authority must complete twenty hours of prelicensing insurance education for each major line of authority for which the applicant will be tested. Each course must include

training on Washington insurance laws and rules applicable to that line of authority and general insurance laws and rules.

(2) The prescribed curriculum for each line of authority to be tested and the related insurance laws and rules, must be successfully completed within the twelve-month period immediately preceding the examination.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-510, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060 and 48.17.070. 89-01-055 (Order R 88-14), § 284-17-510, filed 12/16/88.]

WAC 284-17-515 Waiver of the prelicensing insurance education requirement—Equivalent education. Any person may file a petition with the commissioner for a waiver of the prelicensing insurance education requirement upon completion of equivalent education.

(1) A waiver based on a documentation of equivalent insurance education may be granted by the commissioner in lieu of the certificate of completion of the required prelicensing insurance education if the course of study was completed within the twelve months immediately preceding the date of the petition for waiver and the petitioner demonstrates to the satisfaction of the commissioner that the education meets or exceeds the curriculum required for the applicable line of authority.

(2) Persons successfully completing the following insurance professional designations are deemed to have completed the required prelicensing education requirements and will be issued a waiver of the prelicensing insurance education requirements:

(a) Life insurance: CEBS, ChFC, CIC, CFP, CLU, FLMI, and LUTCF;

(b) Disability insurance: RHU, CEBS, REBC, and HIA; and

(c) Property or casualty insurance: AAI, ARM, CIC, and CPCU.

(3) Except as provided in subsection (2) of this section, the commissioner retains the discretion to determine whether a petitioner has presented sufficient evidence of equivalent education and merits a waiver of the prelicensing insurance education requirement.

(4) The petition must be submitted and the commissioner's written waiver of prelicensing insurance education must have been issued before the petitioner will be admitted to the insurance licensing examination.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-515, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060 and 48.17.150. 91-12-032 (Order R 91-2), § 284-17-515, filed 6/3/91, effective 7/4/91. Statutory Authority: RCW 48.02.060 and 48.17.070. 89-01-055 (Order R 88-14), § 284-17-515, filed 12/16/88.]

WAC 284-17-516 Home self-study—Candidate, course materials and approved providers. (1) A candidate for an insurance producer license examination that undertakes home self-study in lieu of attending a lecture class or proctored self-study, must contact an approved prelicensing insurance education provider to purchase the required course materials.

(2) A list of approved prelicensing insurance education providers is available on the commissioner's web site at www.insurance.wa.gov.

(3) The candidate must complete all prelicensing insurance education requirements set forth in WAC 284-17-510.

(4) After completion of the program of home self-study, the petitioner must provide verification of completion of each course to the prelicensing insurance education provider before the provider can issue a certificate of completion. A certificate of completion is required before the candidate will be admitted to the insurance licensing examination.

(5) The prelicensing insurance education provider must keep accurate purchase and completion rosters of all students participating in home self-study.

(6) "Home self-study" means a form of study using course materials approved by the commissioner and completed away from an insurance school and a course other than a lecture or classroom course. It includes approved internet-based on-line courses accessed from a home computer. The course materials may include textbooks, CDs or reading material accessed on-line from the insurance school's web site.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-516, filed 1/6/09, effective 7/1/09.]

WAC 284-17-517 Home self-study—Materials, course standards. (1) Home self-study course materials must be approved by the commissioner before being used by a prelicensing insurance education provider or offered to a candidate for purchase or use.

(2) To qualify for the commissioner's approval, the prelicensing insurance education provider must demonstrate to the commissioner's satisfaction that the study materials for each course include all prescribed curriculum specified in the examination content outline of the candidate handbook for the particular line of authority.

(3) Each course must be divided into individual lessons covering the prescribed curriculum. The table of contents of the materials must include all of the examination content outline topics as published in the candidate handbook. Each course must cover all required content and must be designed so that a candidate will complete twenty hours of study per line of authority.

(4) Approved prelicensing education providers must apply to the commissioner for amendment to the course approval if there is a change in the content of the study material other than changes made to conform the study materials to modifications of the candidate handbook examination content outline.

(5) Prior to implementation of any change, the prelicensing insurance education provider must advise the commissioner if it makes any change to its course tuition charge or to its rebate policy.

(6) The candidate handbook is available through the commissioner's web site at www.insurance.wa.gov.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-517, filed 1/6/09, effective 7/1/09.]

WAC 284-17-520 Certificates of completion required for admittance to licensing exam—Passing score report must be provided to the commissioner. The requirements of WAC 284-17-505 through 284-17-520 apply to all persons taking an insurance license examination.

(1) In order to be admitted to the examination, an applicant for a resident license with a personal lines, life, disability, property or casualty line of authority must present certificates of completion of the required number of hours of approved prelicensing insurance education or a written waiver.

(2) The commissioner will issue a license after the applicant provides the passing score report, all other required license application documents, and the proper fee.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-520, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060. 89-14-045 (Order R 89-8), § 284-17-520, filed 6/29/89. Statutory Authority: RCW 48.02.060 and 48.17.070. 89-01-055 (Order R 88-14), § 284-17-520, filed 12/16/88.]

WAC 284-17-530 Requirements applicable to all prelicensing insurance education providers. This section applies to all persons seeking to be approved by the commissioner to act as prelicensing insurance education providers.

(1) **Approval to act as prelicensing education providers.** Persons seeking to be approved as prelicensing insurance education providers must obtain the written approval of the commissioner prior to offering any prelicensing insurance education course for credit.

(a) Requests for approval must include all information, disclosures, statements and certifications required by the commissioner. An approved form for this purpose is available on the commissioner's web site at www.insurance.wa.gov.

(b) The provider must comply with the standards for licensing and regulating this state's private vocational schools, but need not be actually licensed as a private vocational school.

(c) The commissioner may grant approval of the prelicensing insurance education provider upon a showing that the provider has satisfied all requirements of this chapter.

(d) Approval of a prelicensing education provider is valid for a period of twelve months.

(2) **Approval of the prelicensing insurance education provider's program director.**

(a) The prelicensing insurance education provider must identify its proposed program director, must complete a background investigation of that person, must certify that the qualifications of the proposed program director meet or exceed the requirements of WAC 284-17-535 and must verify that the proposed program director is trustworthy.

(b) The commissioner's approval of the program director is valid for twelve months.

(c) The provider must certify on its annual renewal notice that the approved individual continues to act as its program director.

(d) The provider must apply for an amendment to its approval at least ten days before changing its program director, unless the change is required due to an emergency.

(e) The commissioner retains discretion to determine whether the qualifications of each proposed program director meet the minimum scholastic and professional criteria required for approval.

(3) **Approval of the provider's instructors.**

(a) The provider must identify each proposed instructor, conduct a background investigation of each individual, certify that each proposed instructor's qualifications meet or exceed the requirements in WAC 284-17-537, and verify that each proposed instructor is trustworthy.

(b) Approval of each instructor is valid until the next renewal date of the prelicensing education provider.

(c) The provider must state on its annual renewal notice whether each individual continues to act as its instructor.

(d) The provider must apply to the commissioner for amended approval at least ten days before adding a new instructor, except if an instructor vacancy is created by an emergency.

(e) The commissioner retains discretion to determine whether the qualifications of each proposed instructor meet the minimum scholastic and professional criteria required for approval.

(4) **Approval of courses.**

(a) Course materials must be submitted to the commissioner prior to use.

(b) The provider must provide all of the following information to the commissioner with its request for course approval:

(i) The total tuition to be charged to students; and

(ii) The provider's referral and rebate policy.

(c) No course may be advertised until the provider has been finally approved by the commissioner in writing.

(5) **Duties of approved providers.** Throughout any period of approval to act as a prelicensing insurance education provider, the provider must:

(a) Retain all student enrollment and performance data, personnel records, and copies of course materials and student evaluations for each course and make them available to the commissioner upon request;

(b) Continually monitor its program director's supervision of instruction;

(c) Immediately remove the program director if that individual violates any law or rule related to insurance;

(d) Apply for amended approval to act as a provider at least ten days prior to a change of ownership, the executive officer, or of the program director. Amended approval, if granted, is valid only until the original provider approval expiration date;

(e) Report to the commissioner by the fifteenth day of each month the name of each student receiving a certificate of completion for each approved course offered during the previous calendar month;

(f) Permit the commissioner or the commissioner's designee to conduct unannounced audits of any approved course in order to monitor the provider's continuing compliance with WAC 284-17-530 through 284-17-580;

(g) Provide a true and complete copy of the provider's instructional plan for each approved course, upon request;

(h) Notify the commissioner if it intends to terminate its prelicensing education program at least thirty days prior to the date of termination;

(i) Notify the commissioner at least ten days in advance of its intent to change the tuition amount, the referral or rebate policy, or initiate a referral or rebate policy with a person other than a full-time employee of the provider.

(6) **Provider advertising and name.** A provider must not:

(a) Use license examination performance data for advertising or promotional purposes; or

(b) Use any name that implies or suggests that the provider is affiliated with either the commissioner or with the independent testing service that conducts the examination.

(7) **Renewal requirements for all providers.**

(a) At the time of renewal all providers must provide all of the following information:

(i) List of prelicensing education courses currently offered and the tuition for each and verify that the course curricula meet the requirements of WAC 284-17-550;

(ii) A description of the instruction method used for each course, lecture, proctored self-study, or home self-study;

(iii) List of all active instructors and verify that each has complied with the requirements of WAC 284-17-537;

(iv) Verify that the program director has complied with WAC 284-17-535; and

(v) Confirm the address and contact information for each business location.

(b) The commissioner may approve renewal of the prelicensing insurance education provider upon a showing that the provider has satisfied all requirements of this chapter required for renewal, including the annual renewal requirements provided in WAC 284-17-547.

(c) Detailed information related to course standards is available on the commissioner's web site at www.insurance.wa.gov.

(8) **Required disclosures to students.**

(a) The prelicensing insurance education provider must disclose to prospective students the total amount of tuition that will be charged for each proposed course.

(b) The provider must post in a conspicuous location at the prelicensing insurance education site a note containing all of the following:

(i) Procedures for applying for an insurance license, including all preexamination qualifications;

(ii) A notice of prohibited examination behavior; and

(iii) The tuition for each approved course.

(c) If the provider has a referral or rebate program, it must be fully disclosed to each student in writing.

(i) The disclosure must state the amount of the course tuition that will be paid to persons other than the provider's full-time employees as compensation for referring students to the provider; and

(ii) The full text of the policy must be posted, including the specific amount of tuition payable to persons other than full-time employees of the provider as compensation for referring students to the provider, and the names of any individuals to whom referral fees or rebates may be paid.

(9) **Penalties.**

(a) The commissioner may refuse to renew or immediately terminate a provider for the following reasons:

(i) Failure to notify the commissioner that a course will be terminated at least thirty days prior to the date of termination;

(ii) Failure to respond to an inquiry of the commissioner within the time limit specified in the inquiry.

(b) A provider is responsible for the conduct of its employees and may be subject to disciplinary action for failure of any employee to comply with the requirements of this chapter.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-530, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060 and 48.17.070. 89-01-055 (Order R 88-14), § 284-17-530, filed 12/16/88.]

WAC 284-17-535 Program director's qualifications and responsibilities. (1)(a) A program director must have at least five years of teaching experience and knowledge of insurance products, principles, laws and rules.

(b) Each independent prelicensing insurance education provider's program director must possess and hold in good standing a Washington insurance license and possess scholastic or professional credentials acceptable to the commissioner.

(c) The requirements of this subsection do not apply to program directors employed by community or technical colleges governed by the state board for community and technical colleges.

(2) A program director must have a history of employment demonstrating administrative educational experience.

(3) A program director must be trustworthy. A program director is not trustworthy if he or she has violated any law or rule pertaining to insurance or to any other regulated occupation, has had an occupational or professional license revoked in any state, or has been convicted of a crime reasonably related to his or her honesty or integrity.

(4) The program director must fully disclose to the commissioner any regulatory or legal action related to his or her honesty, integrity, or professional or occupational activities.

(5) A program director's responsibilities include:

(a) Conducting a background investigation to ascertain that each instructor is trustworthy and qualified to teach the line of authority he or she has been designated to instruct, except as follows:

(i) In the event of an emergency created by the unavoidable absence of an approved instructor, the program director may appoint an interim instructor who was not previously certified and approved to complete the current course offering;

(ii) If it is necessary to appoint an interim instructor, the program director must immediately notify the commissioner of the nature of the emergency, the name of the interim instructor, and the date the current course offering will conclude; and

(iii) At the conclusion of the affected course the program director and provider must not continue to offer the affected course until an approved instructor is available.

(b) Supervising each approved course and reviewing all completed student evaluations; and

(c) Ensuring that instructors properly issue certificates of completion according to WAC 284-17-539 to students at the end of each course.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-535, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060. 89-19-036 (Order R 89-9), § 284-17-535, filed 9/15/89, effective 10/16/89; 89-14-045 (Order R 89-8), § 284-17-535, filed 6/29/89. Statutory Authority: RCW 48.02.060 and 48.17.070. 89-01-055 (Order R 88-14), § 284-17-535, filed 12/16/88.]

WAC 284-17-537 Prelicensing insurance education instructor qualifications and responsibilities. The prelicensing insurance education provider must submit the name of each proposed prelicensing insurance education instructor to the commissioner for approval.

(1) To qualify as a prelicensing insurance education instructor for an approved provider, each proposed instructor must:

(a) Be experienced. An instructor is experienced if he or she can demonstrate any combination of at least three years of experience instructing insurance education courses, supervising students completing self-paced insurance instructional materials, or experience as an insurance producer.

(b) Be trustworthy. An instructor is not trustworthy if he or she has violated any statute or rule pertaining to insurance or to any other regulated occupation, has had an occupational or professional license revoked in any state, or has been convicted of a crime reasonably related to his or her honesty or integrity.

(c) Be competent. An instructor is competent in the line of authority he or she proposes to teach if:

(i) He or she possesses and holds in good standing a Washington insurance producer license for the applicable line(s) of authority; and

(ii) He or she has a current license or provides to the satisfaction of the commissioner evidence of appropriate scholastic or professional credentials reasonably equivalent to an insurance license.

(2) The instructor of each approved course must perform all of the following instructional and administrative duties:

(a) At the beginning session of each approved course, ensure that each student has been properly registered.

(b) Remain on the premises whenever instruction is being offered.

(c) Ensure that the study materials incorporate the prescribed curriculum and follow the lesson plans filed with the commissioner.

(d) Teach approved courses on a live-instruction basis or combine live instruction with the use of other instructional aids, or proctor student use of self-paced insurance instructional materials.

(e) At the conclusion of the course, distribute a course evaluation form to each student who completes the course and collect the completed forms.

(i) A form that can be used for evaluation of a course is available at the commissioner's web site at www.insurance.wa.gov.

(ii) A copy of each evaluation must be available to the commissioner upon request for three years after conclusion of the course.

(f) Issue a signed certificate of completion to each student who completes the course that certifies that the student actually completed the course. The certificate and signature may be in electronic form.

(g) Review course evaluations with the program director.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-537, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060. 89-14-045 (Order R 89-8), § 284-17-537, filed 6/29/89. Statutory Authority: RCW 48.02.060 and 48.17.070. 89-01-055 (Order R 88-14), § 284-17-537, filed 12/16/88.]

WAC 284-17-539 Certificates of completion of a prelicensing insurance education course. (1) A certificate of completion in the standard form prescribed by the commissioner must be completed in its entirety, signed by the instructor, and issued by the approved prelicensing insurance education provider to each student in the student's legal name, who has satisfactorily completed an approved course.

(2) Both the student and the instructor(s) must certify that the course was conducted and completed according to the credit hours and curriculum required.

(3) The provider must include on the face of the certificate of completion the correct codes assigned by the commissioner to each approved prelicensing insurance education provider and to each approved course.

(4) The approved prelicensing insurance education provider must issue certificates of completion within two business days after the course is completed.

(5) No instructor may issue a certificate of completion to herself or himself.

(6) Completion of less than the full course curriculum, or of individual classes does not qualify a student to receive a certificate of completion.

(7) A valid certificate of completion (or a valid waiver) for the line of authority on which the student will be examined must be presented to the independent testing service as a prerequisite to taking any insurance license examination.

(8) The certificate of completion for the prelicensing insurance education course will be accepted for twelve months after the course completion date. Unless waived in accordance with RCW 48.17.175, a prelicensing insurance education course must be retaken if a student does not pass the required examination within twelve months after completion of prelicensing education.

(9) The certificate of completion and required signature may be in electronic form.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-539, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060 and 48.17.070. 89-01-055 (Order R 88-14), § 284-17-539, filed 12/16/88.]

WAC 284-17-540 Requirements applicable to independent prelicensing insurance education providers. In addition to the requirements set forth in WAC 284-17-530, all independent providers must comply with the following additional requirements:

(1) The proposed program director must meet the standards set forth in WAC 284-17-535.

(2) The proposed instructors must be in good standing with the commissioner and must meet the standards set forth in WAC 284-17-537.

(3) All tuition funds received must be promptly deposited into an account separate from any other account or depository.

(4) The accounting system used must provide an audit trail so that details underlying the summary data can be identified.

(5) Records of tuition accounting must be available for inspection by the commissioner during regular business hours for three years after the date of the transaction.

(6) Lecture or proctored self-study courses must be offered at one or more physical locations accessible to the public within Washington.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-540, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060. 89-19-036 (Order R 89-9), § 284-17-540, filed 9/15/89, effective 10/16/89; 89-14-045 (Order R 89-8), § 284-17-540, filed 6/29/89. Statutory Authority: RCW 48.02.060 and 48.17.070. 89-01-055 (Order R 88-14), § 284-17-540, filed 12/16/88.]

WAC 284-17-545 Requirements applicable to insurer-based prelicensing education providers. In addition to the requirements set forth in WAC 284-17-530, all insurer-based providers are subject to the following additional requirements:

(1) Each course must be supervised from the insurer's corporate level.

(2) If the program director does not hold a current Washington insurance license, the insurer must provide the following to the commissioner:

(a) Description of the program director's qualifications, including educational degrees or professional designations earned;

(b) Summary of the program director's past insurance education and past teaching experience; and

(c) Evidence of past insurance education and insurance licenses held in this or other states.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-545, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060 and 48.17.070. 89-01-055 (Order R 88-14), § 284-17-545, filed 12/16/88.]

WAC 284-17-547 Renewal—Prelicensing insurance education provider. A prelicensing insurance education provider must obtain renewal of the provider's authority, program director, instructors, and courses yearly.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-547, filed 1/6/09, effective 7/1/09.]

WAC 284-17-550 Prelicensing insurance education course standards. (1) No prelicensing insurance education course will be approved unless the Washington insurance statutes and rules applicable to the specific line are incorporated into the curriculum for the line of authority.

(2) To qualify for approval, each course must use study materials that include all required curriculum, as set forth in the examination content outline published in the candidate handbook for each line of authority. The candidate handbook is available through the commissioner's web site at www.insurance.wa.gov.

(3) Each prelicensing insurance education course must be broken into individual lesson components covering the prescribed curriculum and the table of contents must include all examination content outline topics.

(a) The course may include instruction on related subject matter; however, any optional subject matter must be designated as supplementary and must be provided as an addition to the prescribed curriculum hours set forth in WAC 284-17-510.

(b) The provider must certify that the study materials include all of the prescribed curriculum.

(4) No prelicensing insurance education course may be represented as approved until the approved prelicensing insurance education provider has received the commissioner's written approval of the instructor and of the course.

(a) Approved prelicensing insurance education providers must apply to the commissioner for amended course approval if any of the following changes or revisions will be made before the original course approval expiration date:

(i) Change of study materials; or

(ii) Change of location.

(b) Amended approval, if granted, is valid only until the original course approval expiration date.

(5) Detailed requirements of course content are available on the commissioner's web site at www.insurance.wa.gov.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-550, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060. 89-14-045 (Order R 89-8), § 284-17-550, filed 6/29/89. Statutory Authority: RCW 48.02.060 and 48.17.070. 89-01-055 (Order R 88-14), § 284-17-550, filed 12/16/88.]

WAC 284-17-551 Prelicensing insurance education—Candidate handbook. The prelicensing insurance education curriculum is described in the candidate handbook. The candidate handbook is incorporated by reference and its entire contents will be enforced by the commissioner. A copy of the current candidate handbook is available through the commissioner's web site at www.insurance.wa.gov.

(1) Information in the current version of the candidate handbook must be provided to each license candidate at the time of enrollment.

(2) If changes are implemented in the prescribed prelicensing education curriculum, the prelicensing insurance education provider must submit a revised course outline at least fifteen calendar days before the implementation date.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-551, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060 and 48.17.150. 91-12-033 (Order R 91-3), § 284-17-551, filed 6/3/91, effective 7/4/91. Statutory Authority: RCW 48.02.060 and 48.17.070. 89-01-055 (Order R 88-14), § 284-17-551, filed 12/16/88.]

WAC 284-17-560 Providers denied approval. The commissioner may deny approval to any prelicensing insurance education provider if:

(1) The prelicensing insurance education provider refuses or fails to comply with any requirement of chapter 284-17 WAC, including but not limited to the provider's employment and use of an unqualified program director or instructor; or

(2) Any owner, program director, or instructor, directly or indirectly, compromises or attempts to compromise the integrity or security of Washington state licensing examination questions, or has induced another to do so; or

(3) Any owner, program director, or instructor:

(a) Fails to comply with any of the requirements of any statute or rule pertaining to the transaction of insurance or to insurance education;

(b) Violates any statute, rule, or copyright related to an examination for any occupational or professional license; or

(c) Is convicted of a crime reasonably related to his or her honesty or integrity.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-560, filed 1/6/09, effective 7/1/09. Statutory Authority:

RCW 48.02.060 and 48.17.070. 89-01-055 (Order R 88-14), § 284-17-560, filed 12/16/88.]

WAC 284-17-565 Suspension or revocation of approved prelicensing insurance education providers. (1) The commissioner may suspend or revoke approval of any prelicensing insurance education provider based upon a finding that:

(a) Any owner, program director, or instructor failed to comply with any of the requirements of chapter 284-17 WAC, including but not limited to the failure to employ a qualified program director or instructor(s); or

(b) Any owner, program director, or instructor, directly or indirectly, compromised or attempted to compromise the integrity or security of Washington state insurance licensing examination questions, or has induced another to do so;

(c) The provider failed to maintain an effective instructional program or misrepresented the quality of the instruction provided to the detriment of its students; or

(d) An owner, program director, or instructor is or has been convicted of a crime reasonably related to his or her honesty or integrity.

(2) The commissioner may suspend or revoke approval of any prelicensing insurance education provider based upon a provider's failure to:

(a) Reply promptly to an inquiry of the commissioner.

(b) Submit revised course outlines requested by the commissioner.

(c) Make timely disclosure to the commissioner and to enrolling students at the time of their enrollment about any offer or payment of any rebate, refund, fee, commission, or discount to persons other than the provider's full-time employees made by the provider based on referrals of students to the provider.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-565, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060 and 48.17.070. 89-01-055 (Order R 88-14), § 284-17-565, filed 12/16/88.]

WAC 284-17-572 Fee. No fee is required for applying to become a prelicensing insurance education provider or for requesting the commissioner's approval of a prelicensing insurance education course.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-572, filed 1/6/09, effective 7/1/09.]

WAC 284-17-574 Prelicensing insurance education provider numbers. A prelicensing insurance education provider will be assigned a provider number by the commissioner. That number must be included on all correspondence related to prelicensing insurance education and on all certificates of completion.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-574, filed 1/6/09, effective 7/1/09.]

WAC 284-17-576 Actions by a prelicensing insurance education provider that may result in a fine. The following actions by a prelicensing insurance education provider may result in a fine:

(1) Advertising or offering a course for credit without the prior approval of the commissioner;

(2) Failing to follow the approved course outline;

(3) Issuing fraudulent completion certificates;

(4) Erroneous advertising; or

(5) Failing to comply with any statute or rule pertaining to prelicensing insurance education providers.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-576, filed 1/6/09, effective 7/1/09.]

WAC 284-17-578 Reinstatement of approval of a prelicensing insurance education provider. (1) Reinstatement of a suspended or revoked approval may be made by the commissioner only after acceptance of satisfactory proof that the conditions responsible for the suspension or revocation have been successfully corrected and the possibility of reoccurrence of the violation has been eliminated.

(2) Reinstatement is at the sole discretion of the commissioner.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-578, filed 1/6/09, effective 7/1/09.]

WAC 284-17-580 Grounds for revocation or suspension of approval of a prelicensing insurance education course. (1) Approval of a prelicensing insurance education course associated with a prelicensing provider may be suspended or revoked if the commissioner concludes that any of the following has occurred:

(a) The content of an approved course is significantly changed without notice to and prior approval from the commissioner;

(b) A certificate of completion is issued to a person who did not complete the course;

(c) A certificate of completion is not issued to a person who satisfactorily completed the course;

(d) The actual instruction of the course is found by the commissioner to be inadequate; or

(e) Within fifteen days after the date of the commissioner's request, the prelicensing insurance education provider fails to supply updated descriptions of any course, records, materials, or audit reports.

(2) Reinstatement of approval of a prelicensing insurance education provider is at the sole discretion of the commissioner and is conditioned upon receipt of satisfactory proof that the conditions responsible for the suspension have been corrected and the possibility of reoccurrence of the violation has been eliminated.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-580, filed 1/6/09, effective 7/1/09.]

WAC 284-17-600 Licensing requirements for insurance producers who maintain more than one place of business in the state. (1)(a) If an individual insurance producer transacts the business of insurance out of more than one place of business in this state, in addition to complying with the requirements of RCW 48.17.450, each place of business must be under the charge of an individual properly licensed for the insurance transactions being conducted at the location.

(b) A business entity insurance producer that maintains more than one place of business in this state must have an individual licensed as an insurance producer physically present in the location when the location is open for the trans-

action of insurance to the same extent as would be expected of an insurance licensee operating at a single location.

(2) Each insurance producer involved in an insurance transaction must have all authority necessary for each insurance transaction, whether by direct appointment from the insurer or by affiliation with a business entity.

(3) If a surplus line broker maintains more than one place of business in this state, transactions in any location which require the services of a surplus line broker must be conducted only by a properly licensed individual.

(4) Each failure to comply with this section is an unfair practice pursuant to RCW 48.30.010.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-600, filed 1/6/09, effective 7/1/09. Statutory Authority: RCW 48.02.060 (3)(a), 48.05.140(9), 48.17.060, 48.17.180, 48.17.530 and 48.30.010. 90-22-039 (Order R 90-12), § 284-17-600, filed 11/1/90, effective 1/15/91.]

WAC 284-17-610 Insurance producers and business entities home state. (1) An individual insurance producer may claim only one state as the home state at a time.

(a) Individual insurance producers that claim multiple states as their home state must choose one state to be their home state for all insurance licensing purposes. This will usually be the state chosen for tax reporting.

(b) Insurance producers or business entities that do not claim Washington to be their home state are Washington nonresidents for purposes of Titles 48 RCW and 284 WAC.

(2) Business entities that have a location in this state must have a resident license.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-610, filed 1/6/09, effective 7/1/09.]

WAC 284-17-620 Loans from insurance clients—Reasonable arrangements. RCW 48.17.530 (1)(m) permits the commissioner to define certain reasonable arrangements where an insurance producer may obtain a loan from an insurance client. The commissioner finds that a reasonable arrangement exists when an insurance producer and an insurance client enter into an arms-length commercial transaction, such as for the purchase of real property, and the financial arrangement is based on fair market value.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-620, filed 1/6/09, effective 7/1/09.]

WAC 284-17-625 Documentation of consent to remuneration in addition to a fee where insurance is purchased over the telephone or by electronic means. RCW 48.17.270(5) provides that when insurance is purchased over the telephone or by electronic means for which written consent under RCW 48.17.270(3) cannot be reasonably obtained, consent documented by the insurance producer is acceptable in lieu of the signed written disclosure required by RCW 48.17.270 (3), (4), and (5).

(1) Documentation confirming the consent of the applicant or insured after communication of the information required by RCW 48.17.270(3) is acceptable under RCW 48.17.270(5) if:

(a) The insurance producer sends to the applicant or insured written confirmation of the disclosure;

(b) The written confirmation is sent no later than ten business days after the telephone or electronic purchase; and

(c) A copy of the confirmation is retained by the insurance producer.

(2) In addition, consent documented by a recording that meets the standards of RCW 9.73.030 is acceptable under RCW 48.17.270(5). The recording must be made and maintained in a retrievable format.

(3) The signature of the applicant or insured is not required for consent under this section.

(4) Documentation created under this section must be retained by the insurance producer for five years.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-625, filed 1/6/09, effective 7/1/09.]

WAC 284-17-630 Display of licenses. RCW 48.17.460 requires the display of the license or licenses of each insurance producer, title insurance agent, or adjuster in a conspicuous place in that part of the place of the licensee's business which is customarily open to the public. Licensees whose personal residence is shown on their licenses may obscure their residence addresses as long as the licensee's name can be seen clearly by the public.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-630, filed 1/6/09, effective 7/1/09.]

WAC 284-17-650 Transition rules—July 1, 2009. All licensees and applicants for licenses are urged to read and understand the changes in the insurance producer statutes, new rules and amendments to existing rules related to licensing and insurance education found in chapters 48.17 RCW and 284-17 WAC before July 1, 2009. A link to the statutes and rules is available at the commissioner's web site at www.insurance.wa.gov.

(1) Insurance licenses held on June 30, 2009, as an agent, broker or solicitor will automatically transition to an insurance producer license at 12:01 a.m. on July 1, 2009. For example, persons holding an agent's license on June 30, 2009, will automatically become licensed insurance producers beginning at 12:01 a.m. on July 1, 2009. No application is required for this transition. It will occur automatically by operation of law.

(2) The agent, general agent, broker and solicitor license types will be discontinued on June 30, 2009. After 12:01 a.m. on July 1, 2009, these types of licenses will be merged and converted to an insurance producer license. Additionally, all active appointments or affiliations associated with these license types will be merged and associated with the producer license.

(3) Title insurance agent licenses will not transition to insurance producer licenses.

(4) The limited appointments to an insurer by a resident general agent based on RCW 48.05.310 will be eliminated on June 30, 2009. No conversion of existing limited appointments will occur.

(5) At 12:01 a.m. on July 1, 2009, licenses for the following lines of authority will automatically transition as follows:

Line of authority held on or before June 30, 2009	Line of authority transitioned to on July 1, 2009
Life	Life
Life with a securities license	Variable life and variable annuity products
Disability	Disability
Property	Property
Casualty	Casualty
Marine	Property and casualty
Surety	Surety
Vehicle	Personal lines
Credit life and disability	Limited line credit
Credit casualty	Limited line credit
Credit life and disability, with life, disability, property or casualty	Life, disability, property, casualty, or personal lines
Credit casualty, with life, disability, property or casualty	Life, disability, property, casualty, or personal lines
Travel	Travel

(6) Any license renewed or issued by the commissioner prior to July 1, 2009, will not be reprinted using the new license type or line of authority. Licensees who wish to obtain a new license document should go to the commissioner's web site (www.insurance.wa.gov) after July 1, 2009, for instructions on how to obtain a new license document.

(7) The license, licensing renewal and late fees must be paid beginning July 1, 2009, in accordance with RCW 48.14.010 and 48.17.170.

(8) Applications for late renewal and reinstatement not received by the commissioner as of midnight June 30, 2009, will be processed based on the requirements in effect on July 1, 2009.

(9) Pending applications for an initial or reinstated license or license renewal for agents, general agents, brokers, or solicitors received prior to June 30, 2009, but not approved for issuance until on or after July 1, 2009, will be issued as producer licenses.

(10) Any over-payments received by the commissioner based on fees in effect until July 1, 2009, will not be refunded; however, applicants for licenses, renewals and reinstatements, and assessments for late fees will be assessed and must be paid according to the requirements of RCW 48.14.010 beginning at 12:01 a.m. on July 1, 2009.

[Statutory Authority: RCW 48.02.060, 48.17.005. 09-02-073 (Matter No. R 2008-06), § 284-17-650, filed 1/6/09, effective 7/1/09.]

Chapter 284-23 WAC
WASHINGTON LIFE INSURANCE REGULATIONS

WAC

WAC 284-23-800 Purpose and scope. The purpose of these rules is to prevent the purchase of juvenile life insurance for speculative or fraudulent reasons, by ensuring that insurance underwriting practices consider such risk, and by setting forth the minimum practices required to insure the life of a juvenile. These rules apply to any insurance issued in Washington state on the life of a juvenile.

[Statutory Authority: RCW 48.02.060 and 48.23.345. 09-03-104 (Matter No. R 2007-09), § 284-23-800, filed 1/21/09, effective 2/21/09.]

WAC 284-23-803 Definitions. For the purpose of this rule, the following definitions apply, unless the context clearly requires otherwise:

(1) "Insurable interest" means a relationship to the insured at the time of application congruent with the continuance of the life of the insured, and as further defined in RCW 48.18.030 and 48.18.060(2).

(2) "Juvenile" means a person younger than eighteen years of age.

(3) "Juvenile Life Insurance Contract" means a life insurance contract issued on the life of a juvenile.

(4) "Parent or legal guardian" means a natural parent, an adoptive parent whose status is documented in a final court order of adoption or a court appointed legal guardian for the juvenile. Step-parents who have not legally adopted the juvenile, foster parents, noncustodial parents or relatives acting in loco parentis are not considered parents or legal guardians of the juvenile for purposes of this rule.

[Statutory Authority: RCW 48.02.060 and 48.23.345. 09-03-104 (Matter No. R 2007-09), § 284-23-803, filed 1/21/09, effective 2/21/09.]

WAC 284-23-806 Required procedures and standards for sale of juvenile life insurance policies. Beginning July 1, 2009, an insurer must comply with the following procedures and standards when selling juvenile life insurance policies:

(1) An insurer may refuse an applicant's request for life insurance when the combined life insurance-in-force exceeds the issuing insurer's maximum for juveniles.

(2) Life insurance upon a juvenile may not be made or take effect unless at the time the contract is made, the applicant is a person having an insurable interest in the life of a minor or is a person upon whom the minor is dependent for support and maintenance. The insurer must obtain and keep documentation sufficient to demonstrate that the person applying for the policy has an insurable interest in the life of the insured.

(3) In addition to the signature of the applicant, the following consent as evidenced by signature must be obtained before submitting the application for underwriting:

(a) The parent or legal guardian with whom the juvenile resides must sign the application if the applicant is not a parent or legal guardian.

(b) Any juvenile age fifteen or older must sign the initial application for insurance on the juvenile's life.

(4) An insurer must have justification for selling a life insurance policy on the life of a juvenile in excess of reasonably anticipated costs associated with the juvenile's funeral, other death expenses or costs of mental health treatment for family members or loss of income to the family. The insurer must provide the insurance commissioner with documentation from its records and files to support the justification upon request. The justification must contain the following elements:

(a) The justification must conform to the insurer's established standards and practices for juvenile life insurance or explain any variance.

(b) Identify the amount, if any, of other life insurance contracts on the life of the juvenile which are in force at the time of application.

(c) Whether and to what extent the beneficiary or applicant is dependent on the juvenile for income or other support.

(d) The value of life insurance or accidental death benefits issued for other siblings or immediate family members, and if not grossly proportional to the underwritten policy benefit or individually equivalent to coverage on other family members, why proportionality or equivalency was not required.

(e) Whether the overall amount of insurance on the juvenile exceeds the annual household income, and if so, why such an amount was approved.

(5) For each application for juvenile life insurance rejected by an insurer, each insurer must maintain at its home or principal office a complete file containing the original signed application, underwriting analysis, correspondence with the applicant and any other documents pertinent to the decision to reject the applicant as an insured, for a period of not less than ten years from the date the application was signed by the applicant. Such file shall be subject to inspection by the insurance commissioner.

[Statutory Authority: RCW 48.02.060 and 48.23.345. 09-03-104 (Matter No. R 2007-09), § 284-23-806, filed 1/21/09, effective 2/21/09.]

Chapter 284-29 WAC
TITLE INSURANCE

WAC

WAC 284-29-100 Definitions. For purposes of this rule:

(1) An "affiliate" of, or person "affiliated" with a title insurance agent is a person who directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

(2) "Associates of producers" has the meaning as set forth in RCW 48.29.010 (3)(f).

(3) "Financial interest" has the meaning as set forth in RCW 48.29.010 (3)(d).

(4) "Person" has the meaning as set forth in RCW 48.01.070.

(5) "Producers of title insurance business or producer" has the meaning as set forth in RCW 48.29.010 (3)(e) and also includes associate of producers as set forth in RCW 48.29.010 (3)(f).

(6) "Report of affiliated business ownership" means a report required by RCW 48.29.015 setting forth the name, address, and percent of title orders originating from those persons who have had a financial interest in a title insurance agent.

(7) "Title insurance agent" has the meaning as set forth in RCW 48.17.010(15).

(8) "Title order" has the same meaning as "preliminary report," "commitment," or "binder" as set forth in RCW 48.29.010 (3)(c) and also includes "title policy" as set forth in RCW 48.29.010 (3)(a).

[Statutory Authority: RCW 48.02.060, 48.29.005, and 48.29.015. 09-20-070 (Matter No. R 2008-22), § 284-29-100, filed 10/5/09, effective 11/5/09.]

WAC 284-29-110 No report required. (1) If a title insurance agent does not have any producers of title insurance business or associates of a producer who own a financial interest in the title insurance agent, then the title insurance agent is not required to file the title insurance agent report of affiliated business ownership.

(2) If a title insurance agent is wholly owned through one or more intermediaries of a company traded on a national stock exchange, then the title insurance agent is not required to file the title insurance agent report of affiliated business ownership.

[Statutory Authority: RCW 48.02.060, 48.29.005, and 48.29.015. 09-20-070 (Matter No. R 2008-22), § 284-29-110, filed 10/5/09, effective 11/5/09.]

WAC 284-29-120 Report form. The title insurance agent report of affiliated business ownership form and instructions as to how and where to submit the form are on the commissioner's web site at www.insurance.wa.gov.

[Statutory Authority: RCW 48.02.060, 48.29.005, and 48.29.015. 09-20-070 (Matter No. R 2008-22), § 284-29-120, filed 10/5/09, effective 11/5/09.]

WAC 284-29-130 Report required. (1) The title insurance agent report of affiliated business ownership must be filed with the commissioner annually by March 15th.

(2) If there is any change or addition to the ownership information contained in the annual report, then the title insurance agent must file an amended report with the commissioner within fifteen days after the end of the month in which the title insurance agent learns of the change or addition.

(3) Changes to the information regarding the percent of title orders originating from each of the producers do not need to be filed with the commissioner except with the annual filing. If the title insurance agent discovers or reasonably should have discovered that the information contained in the annual filing was not correct, then the title insurance agent must file an amended report within fifteen days after the end of the month in which the title insurance agent discovered the incorrect information.

[Statutory Authority: RCW 48.02.060, 48.29.005, and 48.29.015. 09-20-070 (Matter No. R 2008-22), § 284-29-130, filed 10/5/09, effective 11/5/09.]

WAC 284-29-140 Identifying producers. (1) If a person who has a financial interest in a title insurance agent also owns a controlling interest in another producer, then the title insurance agent must report this person and the other business entities controlled by the person as producers who have a financial interest in the title insurance agent. For example if John Brown personally has a financial interest in a title insurance agent and John Brown also owns a controlling interest in ABC Realty Co. and XYZ Home Builders Inc., then the title insurance agent, in addition to reporting John Brown as a producer, must also report ABC Realty Co. and XYZ Home Builders Inc. as producers having a financial interest in the title insurance agent.

(2) In reporting producers who have a financial interest in the title insurance agent, the information about the producer must be sufficient to properly identify the person who is directly in a position to refer or influence the referral of title insurance business to the title insurance agent.

(3) If a producer owns the financial interest in the title insurance agent through one or more intermediary entities, then the identity of the producer and the identity of other entities that the producer owns a controlling interest in that are producers must be set forth in the report. For example, if Henry Smith and Frank Jones own an interest in Joint Venture Co., and Joint Venture Co. has a financial interest in the title insurance agent, then Henry Smith and Frank Jones must be identified in the report as producers who have a financial interest in the title insurance agent, in addition to reporting other entities who are producers that are owned by Henry Smith and Frank Jones.

[Statutory Authority: RCW 48.02.060, 48.29.005, and 48.29.015. 09-20-070 (Matter No. R 2008-22), § 284-29-140, filed 10/5/09, effective 11/5/09.]

WAC 284-29-150 Reporting of amount of business. A title insurance agent must make all reasonable and good faith efforts to determine the source of the title orders that it receives. This must also include information that the title insurance agent obtains when it is also acting as an escrow agent for the transaction. For example:

(1) If a title insurance agent receives a title order in which the seller is XYZ Home Builders Inc., owned by John Brown who has a financial interest in the title insurance agent, then it may be assumed that the source of the title order was John Brown (XYZ Home Builders, Inc.) even though the title order may have been directly received from another person.

(2) If the title insurance agent receives a title order from a producer with a financial interest in the title insurance agent held through one or more intermediary entities, then the specific producer must be identified as the source of the title order. For example, Henry Smith and Frank Jones own an interest in Joint Venture Co., and Joint Venture Co. directly holds the financial interest in the title insurance agent. Henry Smith must be reported as the source of the title insurance business for title orders received from Henry Smith. Likewise, Frank Jones must be reported as the source of title insurance business of orders received from Frank Jones. The amount of business received from both Henry Smith and Frank Jones may not be aggregated and reported as being from Joint Venture Co.

(3) If a title insurance agent receives an order in its escrow department from ABC Realty Co. (owned by John Brown who also has a financial interest in the title insurance agent), and the escrow department then places the title order with the title department of the title insurance agent, then the title insurance agent must report the source of the title order as being ABC Realty Inc.

(4) If the title insurance agent handling the transaction, either through its title department or its escrow department, or both, has information that ABC Realty Inc. (owned by John Brown who has a financial interest in the title insurance agent) is one of the real estate companies involved in the transaction, then it must be assumed that ABC Realty Inc. was the source of the title order unless the title insurance agent has sufficient evidence that the title order was referred to the title insurance agent by another producer.

[Statutory Authority: RCW 48.02.060, 48.29.005, and 48.29.015. 09-20-070 (Matter No. R 2008-22), § 284-29-150, filed 10/5/09, effective 11/5/09.]

WAC 284-29-160 Recordkeeping. (1) A title insurance agent must keep and maintain complete and accurate records of the names and business addresses of those persons who have had a financial interest in the title insurance agent who are reasonably known or reasonably believed by the title insurance agent to be producers.

(2) A title insurance agent must keep and maintain records of its title orders sufficient to identify the source of the title orders.

(3) The records required by WAC 284-29-100 through 284-29-160 must be kept by the title insurance agent for a period of three years after the end of the year being reported upon.

(4) All records of a title insurance agent kept pursuant to WAC 284-29-100 through 284-29-160 must be available to the commissioner or the commissioner's representative during regular business hours.

[Statutory Authority: RCW 48.02.060, 48.29.005, and 48.29.015. 09-20-070 (Matter No. R 2008-22), § 284-29-160, filed 10/5/09, effective 11/5/09.]

WAC 284-29-200 Scope and purpose. (1) RCW 48.29.210(2) states: "A title insurer, title insurance agent, or employee, agent, or other representative of a title insurer or title insurance agent shall not, directly or indirectly, give anything of value to any person in a position to refer or influence the referral of title insurance business to either the title insurance company or title insurance agent, or both, except as permitted under rules adopted by the commissioner." WAC 284-29-200 through 284-29-265 establishes standards for acceptable giving of things of value by a title company to any person in a position to refer or influence the referral of title insurance business to the title company. If the thing of value is not clearly and specifically included in WAC 284-29-200 through 284-29-265 as a thing of value that a title company may give to a person, its giving is prohibited.

(2) RCW 48.29.210 not only applies to title insurance producers or associates of producers, but to every person in position, directly or indirectly, to refer or influence the referral of title insurance business.

(3) No title company is required to give to any person any of the things of value that are permitted by WAC 284-29-200 through 284-29-265 and a person is not entitled to

receive any of the permitted things of value from a title company.

(4) Adoption of WAC 284-29-200 through 284-29-265 must not be construed to mean that the commissioner encourages title companies to give anything of value to any person in a position to refer or influence the referral of title insurance business.

(5) Nothing contained in WAC 284-29-200 through 284-29-265 prohibits the payment by a title insurer or title insurance agent to a producer of a return on ownership interest in the title insurer or title insurance agent as set forth in RCW 48.29.213.

(6) Title companies must not enter into any agreement, arrangement, scheme, or understanding or in any other manner pursue any course of conduct, designed to avoid RCW 48.29.210 and WAC 284-29-200 through 284-29-265.

[Statutory Authority: RCW 48.02.060, 48.29.005 and 48.29.210. 09-05-077 (Matter No. R 2008-21), § 284-29-200, filed 2/17/09, effective 3/20/09.]

WAC 284-29-205 Definitions. For purposes of WAC 284-29-200 through 284-29-265:

(1) "Advertising" or "advertisement" means a representation about any product, service, equipment, facility, or activity or any person who makes, distributes, sells, rents, leases, or otherwise makes available such a product, service, equipment, facility, or activity, when the representation:

(a) Is communicated to a person that, to any extent, by content or context, informs the recipient about such product, service, equipment, facility, or activity;

(b) Recognizes, honors, or otherwise promotes such a product, service, equipment, facility, or activity; or

(c) Invites, advises, recommends, or otherwise solicits a person to participate in, inquire about, purchase, lease, rent, or use such a product, service, equipment, facility, or activity.

(2) "Associates of producers" has the same meaning as set forth in RCW 48.29.010 (3)(f).

(3) "Bona fide employee of a title company" means an individual who devotes substantially all of his or her time to performing services on behalf of a title company and whose compensation for these services is in the form of salary or its equivalent by the title company.

(4) "Commercial real estate" means a fee title interest or possessory estate in real property located in this state, except an interest in real property which is:

(a) Improved with one-single family residential unit or multifamily structure with four or less residential units;

(b) Unimproved and the maximum permitted development is one to four residential units or structures under the county or city zoning ordinances or comprehensive plan applicable to that real estate;

(c) Classified as farm and agricultural land or timber land for assessment purposes under chapter 84.34 RCW; or

(d) Improved with singe-family residential units such as condominiums, townhouses, timeshares, or stand-alone houses in a subdivision that may be legally sold, leased, or otherwise disposed of on a unit-by-unit basis.

(5) "Give" means to transfer to another person, or cause another person to receive, retain, use or otherwise benefit from a thing of value whether or not the title company receives compensation in return. It also means the transfer to a third person of anything of value that in any manner benefits a person in a position to refer or influence the referral of title insurance business.

(6) "Market rate" means the price at which a seller, under no obligation or duress to sell, is willing to accept and a buyer, under no obligation or duress to buy, is willing to pay in an arms-length transaction. The market rate is determined by comparing the items or services purchased or sold to similar items or services that have been recently purchased by others or sold to others, including others not in the title insurance business.

(7) "Person" has the meaning set forth in RCW 48.01.070.

(8) "Producers of title insurance business" or "producer" has the meaning set forth in RCW 48.29.010 (3)(e); this term includes associates of producers and any person in a position to refer or influence the referral of title business to the title company.

(9) "Representative of a title company" means any person acting directly or indirectly on behalf of the title company.

(10) "Restrictive covenants" means private agreements that restrict the use or occupancy of real property generally by specifying lot sizes, building lines, occupancy, architectural styles, and the use to which the property may be put. Restrictive covenants do not include matters such as easements and road maintenance agreements.

(11) "Self-promotional" means an advertisement or promotional function which is conducted by a single title company solely for the benefit of the title company or a promotional item intended for distribution by a single title company and only on behalf of the title company.

(12) "Thing of value" means anything that has a monetary value. It includes but is not limited to cash or its equivalent, tangible objects, services, use of facilities, monetary advances, extensions of lines of credit, creation of compensating balances, title company employee time, advertisements, discounts, salaries, commissions, services at special prices or rates, sales or rentals at special prices or rates, and any other form of consideration, reward or compensation.

(13) "Title company" means either a title insurance company authorized to conduct title insurance business in this state under chapter 48.05 RCW or a title insurance agent defined in RCW 48.17.010(15), or both. The term includes employees, representatives, and agents of title insurance companies and title insurance agents.

(14) "Trade association" means an association of persons, a majority of whom are producers or persons whose primary activity involves real property. Trade association does not include an association of persons, a majority of whom are title insurance companies and title insurance agents.

[Statutory Authority: RCW 48.02.060, 48.29.005 and 48.29.210. 09-05-077 (Matter No. R 2008-21), § 284-29-205, filed 2/17/09, effective 3/20/09.]

WAC 284-29-210 Real property information. (1) A title company may give to a producer without charge information about a specific parcel of real property located in any county, commonly referred to as a "listing package," which consists of information relating to the ownership and status of title to real property. The listing package must be limited to a single copy of one or more of the following six items of information:

(a) The last deed appearing of record;

(b) Deeds of trust, mortgages, and real estate contracts which appear to be in full force and effect;

(c) A map of the property which may show the property's location or dimensions, or both;

(d) Applicable restrictive covenants;

(e) Tax information; and

(f) Property characteristics such as number of rooms, square footage and year built.

(2) A listing package must not include any other real property information such as market value information, demographics, or additions, addenda, or attachments which may be construed as conclusions reached by the title company regarding matters of marketable ownership or encumbrances.

(3) A generic cover letter printed on the standard letterhead of the title company may be attached to the listing package.

(a) The cover letter may include a brief statement identifying by name only, any of the six permitted items included in subsection (1) of this section that may be attached to the cover letter;

(b) The cover letter may contain a disclaimer as to conclusions of marketable ownership or encumbrances; and

(c) The content of the cover letter or listing package is strictly limited to the items listed in this section and must not include any advertising or marketing for the benefit of the recipient.

(4) A title company may give, without charge, to a producer a single copy of a document affecting title to a specific parcel of real property only if:

(a) The cost to the title company of giving the copy of the document, including but not limited to labor and materials, is ten dollars or less; and

(b) The document is not in any manner given to the producer in conjunction with or in association with the giving of other documents related to property in the general locale for which the single document is being given.

(5) A title company must not give a producer reports containing publicly recorded information, comparable sale information, appraisals, estimates, or income production potential, information kits or similar packages containing information about one or more parcels of real property, except as permitted by this section, without charging and actually receiving payment for the actual cost of the work performed and the material provided (for example, costs related to providing farm packages, labels, lot book reports, home books, and tax information).

(6) A title company may give, at no charge, to the proposed insured or insured, copies of any documents set forth as exceptions in a commitment or policy.

(7) If a title company owns or leases and maintains a complete set of tract indexes in a particular county in which the county government does not make copies of recorded documents available on the county's web site, then the title company may make copies of the recorded documents available at no charge to the general public on the title company's web site.

[Statutory Authority: RCW 48.02.060, 48.29.005 and 48.29.210. 09-05-077 (Matter No. R 2008-21), § 284-29-210, filed 2/17/09, effective 3/20/09.]

WAC 284-29-215 Advertising. (1) A title company may advertise in a trade association publication only if all of the following conditions are met:

(a) The publication is an official publication of the trade association;

(b) The publication must be nonexclusive so that any title company has an equal opportunity to advertise in the publication;

(c) The title company must pay no more than the standard rate for the advertisement applicable to members of the trade association;

(d) The title company's advertisement must be solely self-promotional; and

(e) The payment for the advertisement must be included as an expenditure for the purposes of the limits in WAC 284-29-220(5).

(2) Except as provided in subsection (1) of this section, a title company must not directly, indirectly, by payment to a third-party or otherwise, use any means of communication or media to advertise on behalf of, for, or with a producer, including but not limited to:

(a) Advertising real property for sale or lease unless the property is owned by the title company;

(b) Advertising or promoting the listings of real property for sale by real estate licensees; or

(c) Advertising in connection with the promotion, sale, or encumbrance of real property.

(3) No advertisement may be placed in a publication that is published or distributed by or on behalf of a producer of title business, including but not limited to, web sites, flyers, postcards, for sale signs, flyer boxes, or any other means of communication or any other media.

(4) Title companies may pay for a self-promotional advertisement in the publications or broadcasts of the following persons:

(a) Newspapers;

(b) Telephone directories;

(c) Internet web sites, subject to the limits of subsection (3) of this section;

(d) Television stations;

(e) Radio stations; and

(f) Real estate licensees who do not represent buyers and sellers or who do not function as agents as defined in RCW 18.86.010(2) provided that the publication must be nonexclusive so that any title company has an equal opportunity to advertise in the publication.

[Statutory Authority: RCW 48.02.060, 48.29.005 and 48.29.210. 09-05-077 (Matter No. R 2008-21), § 284-29-215, filed 2/17/09, effective 3/20/09.]

WAC 284-29-220 Trade associations. (1) A title company may donate the time of its employees to serve on a trade association committee.

(2) A title company may donate to, contribute to or otherwise sponsor a trade association event only if all of the following conditions are met:

(a) The event is a recognized association event that generally benefits all members and affiliated members of the association in an equal manner;

(b) The donation must not benefit a selected producer member of the association unless through a random process; and

(c) Solicitation for the donation must be made of all association members and affiliated members in an equal manner and amount.

(3) A title company may pay for its employees and a single guest of each employee to attend trade association events only if all of the following conditions are met:

(a) The title company pays a fee equal to fees paid by producer members of the association in the events;

(b) The title company employees and their guest(s) actually attend the event (except when attendance is prevented by an emergency); and

(c) The guest of the title company employee is not a producer (except where the guest is related to the title company employee by blood or marriage or their domestic partner).

(4) For purposes of this section, trade association events include, but are not limited to, conventions, award banquets, symposiums, educational seminars, breakfasts, lunches, dinners, receptions, cocktail parties, open houses, sporting activities and other similar activities.

(5) A title company may:

(a)(i) Donate to, contribute to, or otherwise sponsor a trade association event under subsection (2) of this section;

(ii) Advertise in a trade association publication under WAC 284-29-215(1); and

(iii) Sponsor a trade association educational seminar under WAC 284-29-235(3);

(b) Give a thing of value listed under (a) of this subsection to a trade association only if all of the following requirements are met:

(i) The thing of value is limited to one thousand dollars per event, advertisement, or sponsorship of an educational seminar;

(ii) The title company must not give a thing of value to all trade associations more than three times in a calendar year;

(iii) The title company must not combine any of these permitted expenditures into one expenditure; and

(iv) The title company must not accumulate or carry forward left over or unused expenditures from one of these permitted expenditures to a subsequent expenditure.

(6) If a title company owns or leases and maintains a complete set of tract indexes in more than one county:

(a) The limits set forth in subsection (5) of this section apply on a county by county basis for donations, contributions, sponsorships, payments for events, advertisements, or sponsorship of educational seminars of trade associations a majority of whose members are located in that county;

(b) A donation, contribution, sponsorship, payment for an event, advertisement, or sponsorship of an educational seminar to a statewide trade association shall constitute one of its expenditures for each and every county in which the title company is authorized to issue title insurance policies; and

(c) The title company must not combine or accumulate unused expenditures of these permitted expenditures from one county to another county nor to a statewide trade association.

(7) If a title company that is under common ownership makes a donation, contribution, sponsorship, payment for an event, advertisement, or sponsorship of an educational seminar to a statewide trade association, the expenditure shall constitute an expenditure as one of the expenditures for each and every one of the title companies that are under common control.

[Statutory Authority: RCW 48.02.060, 48.29.005 and 48.29.210. 09-05-077 (Matter No. R 2008-21), § 284-29-220, filed 2/17/09, effective 3/20/09.]

WAC 284-29-225 Self-promotional items. A title company may give a thing of value with its preprinted company logo, except money or gift cards, to a producer if the cost to the title company is five dollars or less per thing of value and only if the thing of value does not contain the name or logo of the producer or any reference to the producer.

[Statutory Authority: RCW 48.02.060, 48.29.005 and 48.29.210. 09-05-077 (Matter No. R 2008-21), § 284-29-225, filed 2/17/09, effective 3/20/09.]

WAC 284-29-230 Permitted business entertainment. (1) A title company may make expenditures for business meals on behalf of any individual, only if the expenditure meets all the following criteria:

(a) An individual representing the title company is present during the business meal;

(b) There is a substantial and substantive title insurance business discussion directly before, during or after the business meal;

(c) No more than four individuals that are employed by or are independent contractors of the same producer are provided a business meal during a single event (spouses and guests of the producer must be included in the count for purposes of determining the four-person maximum); and

(d) The title company does not expend more than one hundred dollars per individual throughout any calendar year for all business meals.

(2) The business meals permitted in subsection (1) of this section must not include open houses of producers wherever located, including but not limited to, at the producers premises or facilities or homes of property for sale.

(3) For purposes of this section, "meals" includes, but is not limited to, breakfast, brunch, lunch, dinner, receptions, or cocktails and other beverages, whether the meals occur on or off the title company's premises.

(4) For purposes of determining the maximum permitted expenditure under subsection (1) of this section, all of the following requirements must be met:

(a) All costs associated with a meal must be included in the calculation of expenses. When calculating the cost of a meal, the title company must include all costs paid by the title company for travel, transportation, hotel, equipment or facility rental, food, cocktails and other beverages, refreshments, and registration or entry fees, except those fees incurred solely by the title company and that do not benefit the producer.

(b) Attendance at or an invitation to a meal must not be based on or be given as compensation for forwarding or directing title business to the title company.

(c) For accounting purposes, the expenditures by a title company for a meal may be prorated among all attendees, including the title company employees.

(5) A title company may host no more than two self-promotional functions per year, only if all of the following requirements are met:

(a) Any self-promotional function must be at the title company's owned or occupied facility at which the title company conducts its regular business. The self-promotional function must be nonexclusive and open to all producers.

(b) A title company must not spend more than fifteen dollars per guest reasonably expected to attend at any one self-promotional function.

(c) A title company must not combine permitted expenditures for two self-promotional functions into a single self-promotional function.

(d) A title company must not accumulate or carry forward left over or unused expenditures from one self-promotional function to a subsequent self-promotional function.

(e) If a title company owns or leases and maintains a complete set of tract indexes in more than one county, then the limits set forth in this subsection apply on a county by county basis.

(i) The self-promotional functions must be at the title company's owned or occupied facility at which the title company conducts its regular business in the county for which it owns or leases and maintains a complete set of tract indexes.

(ii) The title company must not combine permitted expenditures for a self-promotional function from one county to another county.

(6) The limits contained in subsections (1) and (5) of this section are separate limits and an expenditure made for an activity under one of these subsections is not applied to the limit under the other subsection.

[Statutory Authority: RCW 48.02.060, 48.29.005 and 48.29.210. 09-05-077 (Matter No. R 2008-21), § 284-29-230, filed 2/17/09, effective 3/20/09.]

WAC 284-29-235 Educational seminars. (1) A title company may conduct educational programs at no charge only if the content of the program consists solely of education regarding title insurance, title to real property, and escrow topics.

(a) A title company must spend no more than ten dollars per person for refreshments at any one educational program.

(b) Any materials that the title company provides to attendees must be directly related to the topic of the seminar or are self-promotional advertising of the title company.

(2) A title company may provide a speaker at no charge for an educational program conducted or presented by other persons, only if the following conditions are met:

(a) The speaker is an employee of the title company;

(b) If a title insurance agent is providing the speaker, the speaker may be an employee of the title insurer for whom the title insurance agent has been properly appointed;

(c) The topic of the presentation by the employee is solely related to title insurance, escrow, or real property law; and

(d) Any materials that the speaker provides to attendees are directly related to the topic of the speaker or are self-promotional advertising of the title company of the employee.

(3) A title company may sponsor an educational seminar of a trade association subject to the limits in WAC 284-29-220.

(4) A title company may sponsor an educational program on topics other than title insurance, title to real property, and escrow only if:

(a) The educational program is open to all producers; and

(b) The attendees actually pay to attend the program the greater of:

(i) All expenses and costs associated with the delivery of the educational program by the title company; or

(ii) What the attendee would pay to attend a similar seminar sponsored by entities other than title companies on the open market.

The calculation by the title company of the expenses and costs associated with the delivery of the education program must include, but not be limited to, all travel, refreshments, speaker fees or wages of the speaker, facility rental, preparation of materials distributed at the program, parking, advertisement, and wages of arranging and planning for the program.

[Statutory Authority: RCW 48.02.060, 48.29.005 and 48.29.210. 09-05-077 (Matter No. R 2008-21), § 284-29-235, filed 2/17/09, effective 3/20/09.]

WAC 284-29-240 Political action committees. Title companies and their employees may donate to registered political action committees.

[Statutory Authority: RCW 48.02.060, 48.29.005 and 48.29.210. 09-05-077 (Matter No. R 2008-21), § 284-29-240, filed 2/17/09, effective 3/20/09.]

WAC 284-29-245 Locale of title company employees. A title company and its employees must not lease or rent a workspace location owned or leased by a producer unless all of the following conditions are met:

(1) The space is secured by a bona fide written lease or rental agreement;

(2) The rent paid for the workspace is consistent with the prevailing rent charged for similar space in the market area of the workspace;

(3) Renting the space is not contingent upon the volume of title company business and is paid only in cash and not by trade or barter;

(4) There is no sharing of employees unless the title company only pays for its reasonably proportionate share;

(5) There is no common usage of equipment between the title company and the producer unless the title company only pays for its proportionate share; and

(6) The workspace is occupied by a bona fide employee of the title company a minimum thirty hours per week, except for holidays and bona fide emergencies, and is open to the public during regular business hours. However, if for appropriate business reasons the title company ceases conducting business at the locale and there is a remaining term on the lease or rental agreement, the title company may continue to pay the rent until the expiration of the lease or rental agreement or the next renewal date of the lease or rental agreement, whichever is earlier.

[Statutory Authority: RCW 48.02.060, 48.29.005 and 48.29.210. 09-05-077 (Matter No. R 2008-21), § 284-29-245, filed 2/17/09, effective 3/20/09.]

WAC 284-29-250 Memorial gifts and charitable contributions—Limitations. (1) A title company may provide no more than two hundred dollars in value of food, floral bouquets, or memorial donations for the death of a producer or a producer's immediate family member. This includes contributions to medical funds for a producer or a producer's seriously injured or seriously ill immediate family member.

(2) A title company may contribute to a charity only if:

(a) The contribution by the title company is made payable directly to the charity; and

(b) The solicitation for the contribution and the contribution are not, directly or indirectly, in exchange for the referral of title insurance business.

(3) Title company employees may attend and volunteer their time at events hosted by charities.

[Statutory Authority: RCW 48.02.060, 48.29.005 and 48.29.210. 09-05-077 (Matter No. R 2008-21), § 284-29-250, filed 2/17/09, effective 3/20/09.]

WAC 284-29-255 Other things of value that title companies are permitted to give to producers. (1) A title company must not give, offer to give, provide, or offer to provide nontitle services (for example: Computerized bookkeeping, forms management, computer programming, trust accounting for trust accounts not held in the name of the title company, short sale consultants, or transaction coordination) or any similar benefit to a producer, without charging and actually receiving a fee equal to the value of the services provided and in an amount at not less than what the producer would pay if the services were purchased on the open market or the title company's cost to provide the service, whichever is greater.

(2) A title company must not allow the use of any part of its premises (for example, its conference rooms or meeting rooms) to a producer without receiving a fair rental charge equal to the average rental for similar premises in the area.

(3) A title company may allow the use of a part of its premises (for example, its conference rooms or meeting rooms) for no charge to a meeting of a trade association for no more than four meetings in a calendar year.

(4) Title company employees may attend activities and business meetings of producers if all of the following standards are met:

(a) There is no cost to the employee or title company other than the employee's own entry fees, registration fees, meals, or other costs associated with the activity or business meeting;

(b) The fees paid by the title company are no greater than those charged to producer attendees; and

(c) If the title company pays a fee for an employee to attend the activity or business meeting, the title company employee must actually attend the activity or business meeting, unless an emergency prevents attendance.

(5) A title company may advance the recording fees for transactions for which the title company is either issuing the title insurance or conducting the escrow, or both, provided the title company is promptly reimbursed for the recording fees that it advanced.

[Statutory Authority: RCW 48.02.060, 48.29.005 and 48.29.210. 09-05-077 (Matter No. R 2008-21), § 284-29-255, filed 2/17/09, effective 3/20/09.]

WAC 284-29-260 Examples of prohibited matters. The following is a partial, nonexclusive list of things of value that a title company must not give to a producer. Even though a thing of value is not included on this list a title company must not give any other things of value to a producer unless clearly and specifically permitted by WAC 284-29-200 through 284-29-255.

(1) Except as permitted in WAC 284-29-200 through 284-29-255:

(a) A title company must not cosponsor, subsidize, or contribute fees, prizes, gifts, or give things of value for a promotional function or activity off the title company's premises whether the function is self-promotional or not.

(b) Examples of off-premises functions or activities include, but are not limited to:

(i) Meetings;

(ii) Meals, including breakfasts, luncheons, dinners or cocktail parties;

(iii) Conventions, installation ceremonies, celebrations, hospitality rooms or similar functions;

(iv) Outings such as boat trips, fishing trips, motor vehicle rallies, sporting events of any kind, gambling trips, hunting trips, ski trips, shopping trips, golf tournaments, trips to or events at recreational or entertainment areas;

(v) Open house celebrations, or open houses at homes or property for sale;

(vi) Dances; or

(vii) Artistic performances.

(2) A title company must not sponsor, subsidize, supply prizes or labor, or otherwise give things of value for promotional activities of producers.

(3) A title company must not give or offer to give, either directly or indirectly, a compensating balance or deposit in a lending institution for the express or implied purpose of influencing the extension of credit by the lending institution to any producer.

(4) A title company must not disburse or offer to disburse on behalf of any person escrow funds held by the title company before the conditions of the escrow applicable to the disbursements are met.

(5) A title company must not advance, pay or offer to advance or pay money on behalf of any person into escrow to facilitate a closing unless:

(a) The property that is the subject of the escrow is owned by or being purchased by the title company;

(b) The payment is made in compliance with a court order requiring the title company to make the payment; or

(c) In settlement of a bona fide dispute for which the title company may be liable.

(6) A title company must not give, pay or offer to pay, either directly or indirectly, or make payment to a third party for the benefit of any producer for:

(a) The services of a title company employee or representative or an outside professional whose services are required by any producer to complete or structure a particular transaction;

(b) The salary or any part of compensation of an employee of a producer;

(c) The salary or any part of the salary, commission, or any other form of compensation to any employee of the title company who is at the same time actively engaged as a producer;

(d) A fee for making an inspection or appraisal of property, whether or not the fee bears a reasonable relationship to the services performed;

(e) Services required to be performed by any producer in his or her professional capacity;

(f) Any evidence of title or copy of the contents of a document which is not produced or issued by the title company;

(g) The rent for all or any part of any space occupied by any producer, except as provided in WAC 284-29-245;

(h) Money, prizes, or other things of value in any kind of a contest or promotional activity;

(i) Any advertisement published in the name of, for, or on behalf of any producer;

(j) A business form of any producer which is provided for the convenience and benefit of the producer, except a form regularly used in the conduct of the title company's business;

(k) Any earnest money purchase agreements or purchase and sale agreements;

(l) Flyer boxes and stands, for sale signs and posts, or services for the placement of any of them;

(m) Postcards, stamps, flyers, newsletters, folders, invitations, copying, cutting or services related to preparing any of these items;

(n) Car washes or coupons for car washes;

(o) Pictures of producers;

(p) Gift cards of in any amount;

(q) Massages;

(r) Discount certificates; or

(s) The cost of or reimbursement for advisory fees.

(7) A title company must not provide, or offer to provide, all or any part of the time or productive effort of any employee of the title company to any producer. For example, title company employees must not be used by or loaned out to a producer for the self-promotional interests of the producer except as part of the title company's day-to-day business with producers.

(8) A title company must not give or offer to give, pay for, or offer to pay for, furniture; office supplies, including but not limited to, file folders, telephones, computers or other equipment; or automobiles to any producer. A title company must not pay for, or offer to pay for, any portion of the cost of renting, leasing, operating, or maintaining any of these items.

(9) Delivery services between a title company and a producer must be performed by the title company's messenger service or employees and must consist only of delivering items directly related to the title company's title insurance or escrow business from the title company to a producer or from a producer to the title company.

(10) In accordance with its title insurance rates filed with the commissioner, a title company must not provide a title insurance commitment without actually receiving payment for the cancellation fee:

(a) For commitments on noncommercial property, within the earlier of the following:

(i) One hundred eighty days of the first issuance of the commitment; or

(ii) Sixty days of:

(A) The cancellation of the commitment;

(B) When the title company reasonably should know that the commitment has been canceled; or

(C) When the title company reasonably should know that the transaction for which the commitment was issued has been insured by another title company.

(b) For commitments on commercial property, within sixty days of the earlier of the following:

(i) The cancellation of the commitment;

(ii) When the title company reasonably should know that the commitment has been canceled; or

(iii) When the title company reasonably should know that the transaction for which the commitment was issued has been insured by another title company.

(11) A title company must not pay a producer member of its board of directors fees in excess of those paid to nonproducer directors.

(12) A title company must not enter into, agree to, or pay anything of value to a producer under any marketing agreement, access agreement, advertising agreement or any similar agreement.

(13) A title company must not make a donation to any charity in any manner that can reasonably be associated with a producer in exchange for the referral of title insurance business or obtaining customer service information from the title company.

(14) A title company must not pay any fee or consideration to any producer that is in any manner based in whole or in part on the number of transactions between the title company and the producer, regardless of the service being provided.

(15) A title company must not provide escrow, closing, or settlement services for a charge (independent of the rate charged for involved title insurance) that is less than the title company's actual cost either for:

(a) The cost of all parties to the escrow; or

(b) One party's proportionate share of the cost of the escrow.

[Statutory Authority: RCW 48.02.060, 48.29.005 and 48.29.210. 09-05-077 (Matter No. R 2008-21), § 284-29-260, filed 2/17/09, effective 3/20/09.]

WAC 284-29-265 Recordkeeping. (1) A title company must keep and maintain complete, accurate, and sufficient records to demonstrate compliance with WAC 284-29-200 through this section and keep them for a period of five years after the end of the year during which any thing of value was given to a producer.

(2) All records of a title company kept in order to meet the terms of WAC 284-29-200 through this section must be made available to the commissioner or the commissioner's representative during regular business hours.

(3) Failure of the title company to keep the records required by WAC 284-29-200 through this section is a violation of RCW 48.29.210.

[Statutory Authority: RCW 48.02.060, 48.29.005 and 48.29.210. 09-05-077 (Matter No. R 2008-21), § 284-29-265, filed 2/17/09, effective 3/20/09.]

Chapter 284-30 WAC
TRADE PRACTICES

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-30-3901 Definitions for settlement of vehicle claims. [Statutory Authority: RCW 48.02.060, 48.30.010. 03-14-092 (Matter No. R 2002-06), § 284-30-3901, filed 6/30/03, effective 10/1/03.] Repealed by 09-11-129 (Matter No. R 2008-07), filed 5/20/09, effective 8/21/09. Statutory Authority: RCW 48.02.060 and 48.30.010.

284-30-3902 When my vehicle is repairable, what can I expect from the insurer? [Statutory Authority: RCW 48.02.060, 48.30.010. 03-14-092 (Matter No. R 2002-06), § 284-30-3902, filed 6/30/03, effective 10/1/03.] Repealed by 09-11-129 (Matter No. R 2008-07), filed 5/20/09, effective 8/21/09. Statutory Authority: RCW 48.02.060 and 48.30.010.

284-30-3903 Can I get my vehicle repaired at a shop of my choice? [Statutory Authority: RCW 48.02.060, 48.30.010. 03-14-092 (Matter No. R 2002-06), § 284-30-3903, filed 6/30/03, effective 10/1/03.] Repealed by 09-11-129 (Matter No. R 2008-07), filed 5/20/09, effective 8/21/09. Statutory Authority: RCW 48.02.060 and 48.30.010.

284-30-3904 Will my insurer pursue collection of my deductible? [Statutory Authority: RCW 48.02.060, 48.30.010. 03-14-092 (Matter No. R 2002-06), § 284-30-3904, filed 6/30/03, effective 10/1/03.] Repealed by 09-11-129 (Matter No. R 2008-07), filed 5/20/09, effective 8/21/09. Statutory Authority: RCW 48.02.060 and 48.30.010.

284-30-3905 If my insurer collects my deductible back, will I recover the full amount of my deductible? [Statutory Authority: RCW 48.02.060, 48.30.010. 03-14-092 (Matter No. R 2002-06), § 284-30-3905, filed 6/30/03, effective 10/1/03.] Repealed by 09-11-129 (Matter No. R 2008-07), filed 5/20/09, effective 8/21/09. Statutory Authority: RCW 48.02.060 and 48.30.010.

284-30-3906 If another party is responsible for my vehicle damage, can that party's insurer refuse to settle my vehicle damage and force me to use my own collision coverage? [Statutory Authority: RCW 48.02.060, 48.30.010. 03-14-092 (Matter No. R 2002-06), § 284-30-3906, filed 6/30/03, effective 10/1/03.] Repealed by 09-11-129 (Matter No. R 2008-07), filed 5/20/09, effective 8/21/09. Statutory Authority: RCW 48.02.060 and 48.30.010.

284-30-3907 How can my insurer settle my vehicle total loss claim? [Statutory Authority: RCW 48.02.060, 48.30.010. 03-14-092 (Matter No. R 2002-06), § 284-30-3907, filed 6/30/03, effective 10/1/03.] Repealed by 09-11-129 (Matter No. R 2008-07), filed 5/20/09, effective 8/21/09. Statutory Authority: RCW 48.02.060 and 48.30.010.

284-30-3908 Are there factors that may adjust my settlement? [Statutory Authority: RCW 48.02.060, 48.30.010. 03-14-092 (Matter No. R 2002-06), § 284-30-3908, filed 6/30/03, effective 10/1/03.] Repealed by 09-11-129 (Matter No. R 2008-07), filed 5/20/09, effective 8/21/09. Statutory Authority: RCW 48.02.060 and 48.30.010.

284-30-3909 If my vehicle is determined to be a total loss, can I keep it? [Statutory Authority: RCW 48.02.060, 48.30.010. 03-14-092 (Matter No. R 2002-06), § 284-30-3909, filed 6/30/03, effective 10/1/03.] Repealed by 09-11-129 (Matter No. R 2008-07), filed 5/20/09, effective 8/21/09. Statutory Authority: RCW 48.02.060 and 48.30.010.

284-30-3910 Can the insurer move my vehicle prior to settlement of the claim? [Statutory Authority: RCW 48.02.060, 48.30.010. 03-14-092 (Matter No. R 2002-06), § 284-30-3910, filed 6/30/03, effective 10/1/03.] Repealed by 09-11-129 (Matter No. R 2008-07), filed 5/20/09, effective 8/21/09. Statutory Authority: RCW 48.02.060 and 48.30.010.

284-30-3911 What information must be included in the insurer's valuation report? [Statutory Authority: RCW 48.02.060, 48.30.010. 03-14-092 (Matter No. R 2002-06), § 284-30-3911, filed 6/30/03, effective 10/1/03.] Repealed by 09-11-129 (Matter No. R 2008-07), filed 5/20/09, effective 8/21/09. Statutory Authority: RCW 48.02.060 and 48.30.010.

284-30-3912 What if I, as an insured, accept the settlement based on my insurer's valuation and cannot find a comparable vehicle within a reasonable distance of my vehicle's principally garaged area? [Statutory Authority: RCW 48.02.060 and 48.30.010. 04-01-176 (Matter No. R 2003-07), § 284-30-3912, filed 12/23/03, effective 1/23/04; 03-14-092 (Matter No. R 2002-06), § 284-30-3912, filed 6/30/03, effective 10/1/03.] Repealed by 09-11-129 (Matter No. R 2008-07), filed 5/20/09, effective 8/21/09. Statutory Authority: RCW 48.02.060 and 48.30.010.

284-30-3913 What must the insurer do prior to the denial of storage and towing costs? [Statutory Authority: RCW 48.02.060, 48.30.010. 03-14-092 (Matter No. R 2002-06), § 284-30-3913, filed 6/30/03, effective 10/1/03.] Repealed by 09-11-129 (Matter No. R 2008-07), filed 5/20/09, effective 8/21/09. Statutory Authority: RCW 48.02.060 and 48.30.010.

284-30-3914 When I am dealing with someone else's insurer, what are my rights regarding a rental vehicle? [Statutory Authority: RCW 48.02.060, 48.30.010. 03-14-092 (Matter No. R 2002-06), § 284-30-3914, filed 6/30/03, effective 10/1/03.] Repealed by 09-11-129 (Matter No. R 2008-07), filed 5/20/09, effective 8/21/09. Statutory Authority: RCW 48.02.060 and 48.30.010.

284-30-3915 What if the other person's insurer offers a flat rental amount per day, week, or month? [Statutory Authority: RCW 48.02.060, 48.30.010. 03-14-092 (Matter No. R 2002-06), § 284-30-3915, filed 6/30/03, effective 10/1/03.] Repealed by 09-11-129 (Matter No. R 2008-07), filed 5/20/09, effective 8/21/09. Statutory Authority: RCW 48.02.060 and 48.30.010.

284-30-3916 In a total loss situation, what happens if I have a loan or lease on my vehicle and the outstanding balance exceeds the actual cash value of my vehicle? [Statutory Authority: RCW 48.02.060, 48.30.010. 03-14-092 (Matter No. R 2002-06), § 284-30-3916, filed 6/30/03, effective 10/1/03.] Repealed by 09-11-129 (Matter No. R 2008-07), filed 5/20/09, effective 8/21/09. Statutory Authority: RCW 48.02.060 and 48.30.010.

284-30-410 Effective date. [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.] Repealed by 09-11-129 (Matter No. R 2008-07), filed 5/20/09, effective 8/21/09. Statutory Authority: RCW 48.02.060 and 48.30.010.

284-30-800 Unfair practices applicable to title insurers and their agents. [Statutory Authority: RCW 48.02.060 (3)(a), 48.30.140, 48.30.150, 48.01.030 and 48.30.010(2). 90-20-104 (Order R 90-11), § 284-30-800, filed 10/2/90, effective 11/2/90. Statutory Authority: RCW 48.02.060 (3)(a). 88-11-056 (Order R 88-6), § 284-30-800, filed 5/17/88.] Repealed by 09-05-077 (Matter No. R 2008-21), filed 2/17/09, effective 3/20/09. Statutory Authority: RCW 48.02.060, 48.29.005 and 48.29.210.

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 284-30-400, 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. This regulation may be cited and referred to as the unfair claims settlement practices regulation.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 09-11-129 (Matter No. R 2008-07), § 284-30-300, filed 5/20/09, effective 8/21/09; 78-08-082 (Order R 78-3), § 284-30-300, filed 7/27/78, effective 9/1/78.]

WAC 284-30-310 Scope of this regulation. 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. 09-11-129 (Matter No. R 2008-07), § 284-30-310, filed 5/20/09, effective 8/21/09; 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, WAC 284-30-300 through 284-30-400:

(1) "Actual cash value" means the fair market value of the loss vehicle immediately prior to the loss.

(2) "Claimant" means, depending upon the circumstance, either a first party claimant, a third party claimant, or both and includes a claimant's designated legal representative and a member of the claimant's immediate family designated by the claimant.

(3) "Comparable motor vehicle" means a vehicle that is the same make and model, of the same or newer model year, similar body style, with similar options and mileage as the loss vehicle and in similar overall condition, as established by current data. To achieve comparability, deductions or additions for options, mileage or condition may be made if they are itemized and appropriate in dollar amount.

(4) "Current data" means data within ninety days prior to or after the date of loss.

(5) "File" means a record in any retrievable format, and unless otherwise specified, includes paper and electronic formats.

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

(7) "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.

(8) "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.

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

(10) "Loss vehicle" means the damaged motor vehicle or a motor vehicle that the insurer determines is a "total loss."

(11) "Motor vehicle" means any vehicle subject to registration under chapter 46.16 RCW.

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

(13) "Principally garaged area" means the place where the loss vehicle is normally kept, consistent with the applicable policy of insurance.

(14) "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 the insurer.

(15) "Total loss" means that the insurer has determined that the cost of parts and labor, plus the salvage value, meets or exceeds, or is likely to meet or exceed, the "actual cash value" of the loss vehicle. Other factors may be considered in reaching the total loss determination, such as the existence of a biohazard or a death in the vehicle resulting from the loss.

(16) "Written" or "in writing" means any retrievable method of recording an agreement or document, and, unless otherwise specified, includes paper and electronic formats.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 09-11-129 (Matter No. R 2008-07), § 284-30-320, filed 5/20/09, effective 8/21/09; 78-08-082 (Order R 78-3), § 284-30-320, filed 7/27/78, effective 9/1/78.]

WAC 284-30-330 Specific unfair claims settlement practices defined. The following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices of the insurer in the business of insurance, specifically applicable to the settlement of claims:

(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 fully completed proof of loss documentation has been submitted.

(6) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear. In particular, this includes an obligation to promptly pay property damage claims to innocent third parties in clear liability situations. If two or more insurers share liability, they should arrange to make appropriate payment, leaving to themselves the burden of apportioning liability.

(7) Compelling a first party claimant to initiate or submit to litigation, arbitration, or appraisal to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in such actions or proceedings.

(8) Attempting to settle a claim for less than the amount to which a reasonable person would have believed he or she was entitled by reference to written or printed advertising material accompanying or made part of an application.

(9) Making a claim payment to a first party claimant or beneficiary not accompanied by a statement setting forth the coverage under which the payment is made.

(10) Asserting to a first party claimant a policy of appealing arbitration awards in favor of insureds or first party 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 a first party claimant or his or her physician 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) Failing to expeditiously honor drafts given in settlement of claims. A failure to honor a draft within three working days after notice of receipt by the payor bank will constitute a violation of this provision. Dishonor of a draft for valid reasons related to the settlement of the claim will not constitute a violation of this provision.

(16) Failing to adopt and implement reasonable standards for the processing and payment of claims after the obligation to pay has been established. Except as to those instances where the time for payment is governed by statute or rule or is set forth in an applicable contract, procedures which are not designed to deliver a check or draft to the payee in payment of a settled claim within fifteen business days after receipt by the insurer or its attorney of properly executed releases or other settlement documents are not acceptable. Where the insurer is obligated to furnish an appropriate release or settlement document to a claimant, it must do so within twenty working days after a settlement has been reached.

(17) Delaying appraisals or adding to their cost under insurance policy appraisal provisions through the use of appraisers from outside of the loss area. The use of appraisers from outside the loss area is appropriate only where the unique nature of the loss or a lack of competent local appraisers make the use of out-of-area appraisers necessary.

(18) Failing to make a good faith effort to settle a claim before exercising a contract right to an appraisal.

(19) Negotiating or settling a claim directly with any claimant known to be represented by an attorney without the attorney's knowledge and consent. This does not prohibit routine inquiries to a first party claimant to identify the claimant or to obtain details concerning the claim.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 09-11-129 (Matter No. R 2008-07), § 284-30-330, filed 5/20/09, effective 8/21/09. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 87-09-071 (Order R 87-5), § 284-30-330, filed 4/21/87. 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 are subject to examination by the commissioner or by duly appointed designees. The files must contain all notes and work papers pertaining to the claim in enough detail that pertinent events and dates of the events can be reconstructed.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 09-11-129 (Matter No. R 2008-07), § 284-30-340, filed 5/20/09, effective 8/21/09; 78-08-082 (Order R 78-3), § 284-30-340, filed 7/27/78, effective 9/1/78.]

WAC 284-30-360 Standards for the insurer to acknowledge pertinent communications. (1) Within ten working days after receiving notification of a claim under an individual insurance policy, or within fifteen working days with respect to claims arising under group insurance contracts, the insurer must acknowledge its receipt of the notice of claim.

(a) If payment is made within that period of time, acknowledgement by payment constitutes a satisfactory response.

(b) If an acknowledgement is made by means other than writing, an appropriate notation of the acknowledgement must be made in the claim file of the insurer describing how, when, and to whom the notice was made.

(c) Notification given to an agent of the insurer is notification to the insurer.

(2) Upon receipt of any inquiry from the commissioner concerning a complaint, every insurer must furnish the commissioner with an adequate response to the inquiry within fifteen working days after receipt of the commissioner's inquiry.

(3) For all other pertinent communications from a claimant reasonably suggesting that a response is expected, an appropriate reply must be provided within ten working days for individual insurance policies, or fifteen working days with respect to communications arising under group insurance contracts.

(4) Upon receiving notification of a claim, every insurer must 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 constitutes compliance with that subsection.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 09-11-129 (Matter No. R 2008-07), § 284-30-360, filed 5/20/09, effective 8/21/09; 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 a claim. Every insurer must complete its investigation of a claim within thirty days after notification of claim, unless the investigation cannot reasonably be completed within that time. All persons involved in the investigation of a claim must provide reasonable assistance to the insurer in order to facilitate compliance with this provision.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 09-11-129 (Matter No. R 2008-07), § 284-30-370, filed 5/20/09, effective 8/21/09; 78-08-082 (Order R 78-3), § 284-30-370, filed 7/27/78, effective 9/1/78.]

WAC 284-30-380 Settlement standards applicable to all insurers. (1) Within fifteen working days after receipt by the insurer of fully completed and executed proofs of loss, the insurer must notify the first party claimant whether the claim

has been accepted or denied. The insurer must not deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to the specific 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 must 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 in writing, an appropriate notation must be made in the claim file of the insurer describing how, when, and to whom the notice was made.

(3) If the insurer needs more time to determine whether a first party claim should be accepted or denied, it must notify the first party claimant within fifteen working days after receipt of the proofs of loss giving the reasons more time is needed. If after that time the investigation remains incomplete, the insurer must notify the first party claimant in writing stating the reason or reasons additional time is needed for investigation. This notification must be sent within forty-five days after the date of the initial notification and, if needed, additional notice must be provided every thirty days after that date explaining why the claim remains unresolved.

(4) Insurers must 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 must 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. This notice must be given to first party claimants thirty days and to third party claimants sixty days before the date on which any time limit may expire.

(6) The insurer must not 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 specified 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.

(7) Insurers are responsible for the accuracy of evaluations to determine actual cash value.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 09-11-129 (Matter No. R 2008-07), § 284-30-380, filed 5/20/09, effective 8/21/09; 78-08-082 (Order R 78-3), § 284-30-380, filed 7/27/78, effective 9/1/78.]

WAC 284-30-390 Acts or practices considered unfair in the settlement of motor vehicle claims. In addition to the unfair claims settlement practices specified in this regulation, the following acts or practices of the insurer are hereby defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance, specifically applicable to the settlement of motor vehicle claims:

(1) Failing to make a good faith effort to communicate with the repair facility chosen by the claimant.

(2) Arbitrarily denying a claimant's estimate for repairs.

(a) A denial of the claimant's estimate for repairs to be completed at the chosen repair facility based solely on the repair facility's hourly rate is considered arbitrary if the rate does not result in a higher overall cost of repairs.

(b) If the insurer pays less than the amount of the estimate from the claimant's chosen repair facility, the insurer must fully disclose the reason or reasons it paid less than the claimant's estimate, and must thoroughly document the circumstances in its claim file.

(3) Requiring the claimant to travel unreasonably to:

(a) Obtain a repair estimate;

(b) Have the loss vehicle repaired at a specific repair facility; or

(c) Obtain a temporary rental or loaner vehicle.

(4) Failing to prepare or accept an estimate provided by the claimant that will restore the loss vehicle to its condition prior to the loss.

(a) If the insurer prepares the estimate, it must provide a copy of the estimate to the claimant.

(b) If a claimant provides the estimate and the insurer, after evaluation of the claimant's estimate, determines it owes an amount that differs from the estimate the claimant provided, the insurer must fully disclose the reason or reasons for the difference to the claimant, and must thoroughly document the circumstances in the claim file.

(c) If the claimant chooses to take the loss vehicle to a repair facility where the overall cost to restore the loss vehicle to its condition prior to the loss exceeds the insurer's estimate, the claimant must be advised that he or she may be responsible for any additional amount above the insurer's estimate.

(5) If requested by the claimant and if the insurer prepares the estimate, failing to provide a list of repair facilities within a reasonable distance of the claimant's principally garaged area that will complete the vehicle repairs for the estimated cost of the insurer prepared estimate.

(6) Failing to consider any additional loss related damage the repair facility discovers during the repairs to the loss vehicle.

(7) Failing to limit deductions for betterment and depreciation to parts normally subject to repair and replacement during the useful life of the loss vehicle. Deductions for betterment and depreciation are limited to the lesser of:

(a) An increase in the actual cash value of the loss vehicle caused by the replacement of the part; or

(b) An amount equal to the value of the expired life of the part to be repaired or replaced when compared to the normal useful life of that part.

(8) If provided for by the terms of the applicable insurance policy, and if the insurer elects to exercise its right to repair the loss vehicle at a specific repair facility, failing to prepare or accept an estimate that will restore the loss vehicle to its condition prior to the loss at no additional cost to the first party claimant other than as stated in the applicable policy of insurance.

(9) If liability and damages are reasonably clear, recommending that claimants make a claim under their own collision coverage solely to avoid paying claims under the liability insurance policy.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 09-11-129 (Matter No. R 2008-07), § 284-30-390, filed 5/20/09, effective 8/21/09; 03-14-092 (Matter No. R 2002-06), § 284-30-390, filed 6/30/03, effective 10/1/03. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 87-09-071 (Order R 87-5), § 284-30-390, filed 4/21/87. 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 284-30-391 Methods and standards of practice for settlement of total loss vehicle claims. Unless an agreed value is reached, the insurer must adjust and settle vehicle total losses using the methods set forth in subsections (1) through (3) of this section. Subsections (4) through (6) of this section establish standards of practice for the settlement of total loss vehicle claims. If an agreed value or methodology is reached between the claimant and the insurer using an evaluation that varies from the methods described in subsections (1) through (3) of this section, the agreement must be documented in the claim file. The insurer must take reasonable steps to ensure that the agreed value is accurate and representative of the actual cash value of a comparable motor vehicle in the principally garaged area.

(1) Replacing the loss vehicle: The insurer may settle a total loss claim by offering to replace the loss vehicle with a comparable motor vehicle that is available for inspection within a reasonable distance from where the loss vehicle is principally garaged.

(2) Cash settlement: The insurer may settle a total loss claim by offering a cash settlement based on the actual cash value of a comparable motor vehicle, less any applicable deductible provided for in the policy.

(a) Only a vehicle identified as a comparable motor vehicle may be used to determine the actual cash value.

(b) The insurer must determine the actual cash value of the loss vehicle by using any one or more of the following methods:

(i) Comparable motor vehicle: The actual cash value of a comparable motor vehicle based on current data obtained in the area where the loss vehicle is principally garaged.

(ii) Licensed dealer quotes: Quotations for the cost of a comparable motor vehicle obtained from two or more licensed dealers within a reasonable distance of the principally garaged area not to exceed one hundred fifty miles (except where there are no licensed dealers having comparable motor vehicles within one hundred fifty miles).

(iii) Advertised data comparison: The actual cash value of two or more comparable motor vehicles advertised for sale in the local media if the advertisements meet the definition of current data as defined in WAC 284-30-320(4). The vehicles must be located within a reasonable distance of the principally garaged area not to exceed one hundred fifty miles.

(iv) Computerized source: The insurer may use a computerized source to establish a statistically valid actual cash value of the loss vehicle. The source used must meet all of the following criteria:

(A) The source's data base must produce values for at least eighty-five percent of all makes and models for a minimum of fifteen years taking into account the values of all major options for such motor vehicles.

(B) The source must produce actual cash values based on current data within a reasonable distance of the principally garaged area, not to exceed one hundred fifty miles.

(C) The source must rely upon the actual cash value of comparable motor vehicles that are currently available or were available in the market place within ninety days prior to or after the date of loss.

(D) The source must provide a list of comparable motor vehicles used to determine the actual cash value. If more than thirty comparable motor vehicles are located, the insurer need list only thirty but may list more.

(v) Cash settlement search area: If none of the methods in subsection (2)(b)(i) through (iv) of this section produce a comparable motor vehicle to establish an actual cash value within a reasonable distance of the principally garaged area, the search area may be expanded in increasing circles of twenty-five mile increments, up to one hundred and fifty miles, until two or more comparable motor vehicles are located. If no comparable motor vehicles can be located within one hundred fifty miles, the search area may be expanded with the agreement of the first party claimant.

(3) Appraisal: If the first party claimant and the insurer fail to agree on the actual cash value of the loss vehicle and the insurance policy has an appraisal provision, either the insurer or the first party claimant may invoke the appraisal provision of the policy to resolve disputes concerning the actual cash value.

(4) Settlement requirements: When settling a total loss vehicle claim using methods in subsections (1) through (3) of this section, the insurer must:

(a) Communicate its settlement offer to the claimant by phone or in writing and information about this communication must be documented in the claim file, including the date, time, and name of the person to whom the offer was made.

(b) Base all offers on itemized and verifiable dollar amounts for vehicles that are currently available, or were available within ninety days of the date of loss, using appropriate deductions or additions for options, mileage or condition when determining comparability.

(c) Consider relevant information supplied by the claimant when determining appropriate deductions or additions.

(d) Provide a true and accurate copy of any "valuation report," as described in WAC 284-30-392, if requested.

(e) As part of the settlement amount, include all applicable government taxes and fees that would have been incurred by the claimant if the claimant had purchased the loss vehicle immediately prior to the loss. These taxes and fees must be included in the settlement amount whether or not the claimant retains or subsequently transfers ownership of the loss vehicle.

(5) Settlement adjustments: Insurers may adjust a total loss settlement through the following methods only:

(a) The insurer may deduct from a first party claim the amount of another claim payment (including the applicable deductible) previously made to an insured for prior unrepaired damage to the same vehicle.

(b) Deductions other than those made pursuant to (a) of this subsection may be made for other unrepaired damage as long as the amount of deduction is no greater than the decrease in the actual cash value due to prior damage.

(c) If the claimant retains the total loss vehicle, the insurer may deduct the salvage value from the settlement amount, as described in subsection (4)(e) of this section. Upon a request by the claimant, the insurer must provide the name and address of a salvage entity or dismantler who will purchase the salvage for the amount deducted with no additional charge. This purchase option must remain available for at least thirty days after the settlement agreement is reached

and the claimant must be advised that the salvage entity may not honor its offer if the condition of the salvage has changed.

(d) Any additions or deductions from the actual cash value must be explained to the claimant and must be itemized showing specific dollar amounts.

(6) Reopening a claim file:

(a) The insurer must reopen the claim file if within the first thirty-five days after the date final payment is sent to the first party claimant, lienholder, or both, the claimant is not able to purchase a comparable motor vehicle for the agreed amount but was able to locate, but did not purchase a comparable motor vehicle that costs more than the agreed settlement amount.

(b) If the claimant has satisfied (a) of this subsection, and if the appraisal section of the policy has not been utilized, the insurer must do one of the following:

(i) Locate a comparable motor vehicle that is currently available for the agreed settlement amount;

(ii) Pay the claimant the difference between the agreed settlement amount and the cost of the comparable motor vehicle;

(iii) Purchase the comparable motor vehicle for the claimant; or

(iv) Conclude the loss settlement in the manner provided in the appraisal section of the insurance policy in force at the time of the loss.

(c) The insurer is not required to reopen the claim file if:

(i) The claimant received written notification of the location of a specific comparable motor vehicle available for purchase for the agreed settlement amount and the claimant did not purchase this vehicle within five business days after the date final payment is sent to the claimant, lienholder, or both; or

(ii) The appraisal provision was previously exercised.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 09-11-129 (Matter No. R 2008-07), § 284-30-391, filed 5/20/09, effective 8/21/09.]

WAC 284-30-392 Information that must be included in the insurer's total loss vehicle valuation report. The insurer's total loss vehicle valuation report must include:

(1) All information collected during the initial inspection assessing the condition, equipment, and mileage of the loss vehicle;

(2) All information the insurer used to determine the actual cash value of the loss vehicle;

(3) A list of the comparable motor vehicles used by the insurer to arrive at the actual cash value. This list must include:

(a) The source of the information used;

(b) The date of the information;

(c) The contact information for the seller, the comparable motor vehicle's vehicle identification number, or both;

(d) The seller's asking price;

(e) The sold price, if available; and

(f) The location or contact information for each comparable motor vehicle at the time of the valuation.

(4) When the insurer uses a computerized source for determining statistically valid actual cash values after meeting the requirements of WAC 284-30-391 (2)(b)(iv):

(a) The source must provide a list of comparable motor vehicles used to determine the actual cash value. If more than thirty comparable motor vehicles are used, only thirty must be listed.

(b) Any supplemental information must be clearly identified with a separate heading.

(c) Any weighting of identified vehicles to arrive at an average must be documented and explained.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 09-11-129 (Matter No. R 2008-07), § 284-30-392, filed 5/20/09, effective 8/21/09.]

WAC 284-30-393 Insurer must include an insured's deductible in its subrogation demands. The insurer must include the insured's deductible, if any, in its subrogation demands. Subrogation recoveries must be allocated first to the insured for any deductible(s) incurred in the loss. Deductions for expenses must not be made from the deductible recovery unless an outside attorney is retained to collect the recovery. The deduction may then be made only as a pro rata share of the allocated loss adjustment expense. The insurer must keep its insured regularly informed of its efforts related to the progress of subrogation claims. "Regularly informed" means that the insurer must contact its insured within sixty days after the start of the subrogation process, and no less frequently than every one hundred eighty days until the insured's interest is resolved.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 09-11-129 (Matter No. R 2008-07), § 284-30-393, filed 5/20/09, effective 8/21/09.]

WAC 284-30-394 Denial of storage and towing costs. Prior to denying storage and towing costs, the insurer must do all of the following:

(1) Advise the first party claimant by phone or in writing before it stops payment for storage of the loss vehicle. This communication must be documented in the claim file. If it is a phone call, the documentation must include the date, time, name of the person contacted and a summary of the conversation;

(2) Provide reasonable time for the claimant to move the loss vehicle before stopping payment for storage. Five calendar days is considered reasonable time unless the claimant agrees to a shorter time period;

(3) Pay any and all reasonable towing charges unless otherwise provided in the applicable insurance policy.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 09-11-129 (Matter No. R 2008-07), § 284-30-394, filed 5/20/09, effective 8/21/09.]

WAC 284-30-400 Enforcement. Violations of the standards for unfair claims settlement practices in this regulation are subject to the enforcement provisions set forth in RCW 48.30.010 and 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. 09-11-129 (Matter No. R 2008-07), § 284-30-400, filed 5/20/09, effective 8/21/09; 78-08-082 (Order R 78-3), § 284-30-400, filed 7/27/78, effective 9/1/78.]

WAC 284-30-590 Unfair practices with respect to policy cancellations, renewals, and changes. (1) It is unfair practice to utilize a twenty-day notice to increase premiums by a change of rates or to change the terms of a policy to the adverse interest of the insured thereunder, except on a one time basis in connection with the renewal of a policy as permitted by RCW 48.18.2901(2), or to utilize such notice if it is

not, by its contents, made clearly and specifically applicable to the particular policy and to the insured thereunder or does not provide sufficient information to enable the insured to understand the basic nature of any change in terms or to calculate any premium resulting from a change of rates.

(2) In the unusual situation where a contract permits a midterm change of rates or terms, other than in connection with a renewal, it is an unfair practice to effectuate such change with less than forty-five days advance written notice to the named insured, or to utilize a contract provision which is not set forth conspicuously in the contract under an appropriate caption of sufficient prominence that it will not be minimized or rendered obscure.

(3) It is an unfair practice to effectuate a change of rates or terms other than prospectively. Such changes may be effective no sooner than the first day following the expiration of the required notice.

(4) If an insured elects to not continue coverage beyond the effective date of any change of rates or terms, it is an unfair practice to refund any premium on less than a pro rata basis.

(5) The cancellation and renewal provisions set forth in chapter 48.18 RCW do not apply to surplus line policies. To avoid unfair competition and to prevent unfair practices with respect to consumers, it is an unfair practice for any surplus line broker to procure any policy of insurance pursuant to chapter 48.15 RCW that is cancelable by less than ten days advance notice for nonpayment of premium and twenty days for any other reason, except as to a policy of insurance of a kind exempted by RCW 48.15.160. This rule shall not prevent the cancellation of a fire insurance policy on shorter notice in accord with chapter 48.53 RCW.

(6) Except where the insurance policy is providing excess liability or excess property insurance including so-called umbrella coverage, it is an unfair practice for an insurer to make a common practice of giving a notice of nonrenewal of an insurance policy followed by its offer to rewrite the insurance, unless the proposed renewal insurance is substantially different from that under the expiring policy.

(7) Where the rate has not changed but an incorrect premium has been charged, if the insurer elects to make a midterm premium revision, it is an unfair practice to treat the insured less favorably than as follows:

(a) If the premium revision is necessary because of an error made by the insurer or its agent, the insurer shall:

(i) Notify the applicant or insured of the nature of the error and the amount of additional premium required; and

(ii) Offer to cancel the policy or binder pro rata based on the original (incorrect) premium for the period for which coverage was provided; or

(iii) Offer to continue the policy for its full term with the correct premium applying no earlier than twenty days after the notice of additional premium is mailed to the insured.

(b) If the premium revision results from erroneous or incomplete information supplied by the applicant or insured, the insurer shall:

(i) Correct the premium or rate retroactive to the effective date of the policy; and

(ii) Notify the applicant or insured of the reason for the amount of the change. If the insured is not willing to pay the additional premium billed, the insurer shall cancel the policy, with appropriate statutory notice for nonpayment of premium, and compute any return premium based on the correct premium.

(c) This subsection recognizes that an insurer may elect to allow an incorrect premium to remain in effect to the end of the policy term because the insured is legally or equitably entitled to the benefit of a bargain made.

(8) If a policy includes conditions allowing the insured to cancel the policy, the insured may cancel the policy or binder issued as evidence of coverage.

(a) The insured may provide notice before the effective date of cancellation using one of these methods:

(i) Written notice of cancellation to the insurer or producer by mail, fax or e-mail;

(ii) Surrender of the policy or binder to the insurer or producer; or

(iii) Verbal notice to the insurer or producer.

(b) If the insurer receives notice of cancellation from the insured, it must accept and promptly cancel the policy or any binder issued as evidence of coverage effective the later of:

(i) The date notice is received; or

(ii) The date the insured requests cancellation.

(c) If an insured provides verbal notice of cancellation to the insurer, the insurer may require the insured to provide written confirmation of cancellation, but may not impose a waiting period for cancellation by requiring written confirmation from the insured.

(d) Insurers may retroactively cancel a policy to accommodate the insured.

(e) Insurers must establish safeguards to ensure the person requesting cancellation:

(i) Is authorized to do so; and

(ii) Is informed that the request to cancel the policy is binding on both parties.

[Statutory Authority: RCW 48.02.060. 10-01-074 (Matter No. R 2008-12), § 284-30-590, filed 12/14/09, effective 1/14/10. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 87-09-071 (Order R 87-5), § 284-30-590, filed 4/21/87.]

Chapter 284-44 WAC

HEALTH CARE SERVICES CONTRACTORS—AGENTS—CONTRACT FORMATS—STANDARDS

WAC

WAC 284-44-015 Discretionary clauses prohibited.

(1) No contract may contain a discretionary clause. "Discretionary clause" means a provision that purports to reserve discretion to a carrier, its agents, officers, employees, or designees in interpreting the terms of a contract or deciding eligibility for benefits, or requires deference to such interpretations or decisions, including a provision that provides for any of the following results:

(a) That the carrier's interpretation of the terms of the contract is binding;

(b) That the carrier's decision regarding eligibility or continued receipt of benefits is binding;

(c) That the carrier's decision to deny, modify, reduce or terminate payment, coverage, authorization, or provision of health care service or benefits, is binding;

(d) That there is no appeal or judicial remedy from a denial of a claim;

(e) That deference must be given to the carrier's interpretation of the contract or claim decision; and

(f) That the standard of review of a carrier's interpretation of the contract or claim decision is other than a de novo review.

(2) Nothing in this section prohibits a carrier from including a provision in a contract that informs an insured that as part of its routine operations the carrier applies the terms of its contracts for making decisions, including making determination regarding eligibility, receipt of benefits and claims, or explaining its policies, procedures, and processes.

[Statutory Authority: RCW 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.200, 48.02.060, 48.18.110, 48.44.020, and 48.46.060. 09-16-128 (Matter No. R 2008-25), § 284-44-015, filed 8/5/09, effective 9/5/09.]

Chapter 284-44A WAC

HEALTH CARE SERVICE CONTRACTOR GENERAL RULES FOR ELECTRONIC FILING OF FORMS AND RATES IN SERFF

WAC

WAC 284-44A-010 Definitions that apply to this chapter. The definitions in this section apply throughout this chapter.

(1) "Complete filing" means a package of information containing forms, supporting information, documents and exhibits submitted to the commissioner electronically using the system for electronic rate and form filing (SERFF).

(2) "Date filed" means the date a complete filing has been received and accepted by the commissioner.

(3) "Filer" means:

(a) A person, organization or other entity that files forms or rates with the commissioner for an HCSC; or

(b) A person employed by the HCSC to file under this chapter.

(4) "Form" means a:

(a) "Contract" as defined in WAC 284-43-910; and includes:

(i) Applications;

(ii) Certificates of coverage;

(iii) Disclosure forms;

(iv) Enrollment forms;

(v) Policy forms, including riders;

(vi) Termination notice forms;

(vii) Short form filing summary, as outlined in the SERFF filing instructions; and

(viii) All other forms that are part of the contract.

(b) "Contract form" as defined in WAC 284-43-910;

(c) Network enrollment forms described in WAC 284-43-220(2);

(d) Participating provider agreements as required by RCW 48.44.070; and

(e) Medicare supplement forms required to be filed under chapter 48.66 RCW.

(5) "Health care service contractor" or "HCSC" means the same as in RCW 48.44.010.

(6) "NAIC" means the National Association of Insurance Commissioners.

(7) "Objection letter" means correspondence created in SERFF and sent by the commissioner to the filer that:

(a) Requests clarification, documentation or other information;

(b) Explains errors or omissions in the filing; or

(c) Disapproves a form under RCW 48.44.020 or 48.44.070.

(8) "Rate" or "rates" means all classification manuals, rate manuals, rating schedules, class rates, and rating rules that must be filed under RCW 48.44.040 or 48.66.035.

(9) "Rate schedule" means the same as in WAC 284-43-910.

(10) "SERFF" means the system for electronic rate and form filing. SERFF is a proprietary NAIC computer-based application that allows insurers and other entities to create and submit rate, rule and form filings electronically to the commissioner.

(11) "Type of insurance" or "TOI" means a specific type of health care coverage listed in the *Uniform Life, Accident and Health, Annuity and Credit Coding Matrix* published by the NAIC and available at www.naic.org.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 10-01-118 (Matter No. R 2009-04), § 284-44A-010, filed 12/17/09, effective 1/17/10.]

WAC 284-44A-020 Purpose of this chapter. The purpose of this chapter is to:

(1) Adopt processes and procedures for filers and HCSCs to use when submitting electronic forms and rates to the commissioner by way of SERFF.

(2) Effective July 1, 2010, designate SERFF as the method by which filers and HCSCs must submit all forms and rates to the commissioner.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 10-01-118 (Matter No. R 2009-04), § 284-44A-020, filed 12/17/09, effective 1/17/10.]

WAC 284-44A-030 Scope of this chapter. This chapter applies to all HCSCs that must file forms and rates under RCW 48.44.040, 48.44.070, and 48.66.035.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 10-01-118 (Matter No. R 2009-04), § 284-44A-030, filed 12/17/09, effective 1/17/10.]

WAC 284-44A-040 Filing instructions that are incorporated into this chapter. SERFF is a dynamic application that the NAIC will revise and enhance over time. To be consistent with NAIC filing standards and provide timely instructions to filers, the commissioner will incorporate documents posted on the SERFF web site into this chapter. By reference, the commissioner incorporates these documents into this chapter:

(1) The *SERFF Industry Manual* posted on the SERFF web site (www.serff.com); and

(2) The *Washington State SERFF Health and Disability Rate and Form Filing General Instructions* posted on the commissioner's web site (www.insurance.wa.gov).

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 10-01-118 (Matter No. R 2009-04), § 284-44A-040, filed 12/17/09, effective 1/17/10.]

WAC 284-44A-050 General form and rate filing rules. (1) Each form or rate filing must be submitted to the commissioner electronically using SERFF.

(a) Every form filed in SERFF must:

(i) Be attached to the form schedule; and

(ii) Have a unique identifying number and a way to distinguish it from other versions of the same form.

(b) Filers must send all written correspondence related to a form or rate filing in SERFF.

(2) All filed forms must be legible for both the commissioner's review and retention as a public record. Filers must submit new or revised forms to the commissioner for review in final form displayed in ten-point or larger type.

(3) Filers must submit complete filings that comply with the *SERFF Industry Manual* posted on the SERFF web site (www.serff.com) and the *Washington State Health and Disability Form Filing General Instructions* posted on the commissioner's web site (www.insurance.wa.gov).

(4) Filers must submit separate filings for each type of insurance.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 10-01-118 (Matter No. R 2009-04), § 284-44A-050, filed 12/17/09, effective 1/17/10.]

WAC 284-44A-060 Specific rate filing rules. (1) If a rate filing is required under RCW 48.44.040 or 48.66.035, the filer must submit it:

(a) Separate from any corresponding form filing; and

(b) Concurrently with the corresponding form filing if new forms are being introduced.

(2) Each rate filing must include, if appropriate:

(a) Rates schedules;

(b) Actuarial data that supports the:

(i) Proposed rate schedules; and

(ii) Anticipated loss ratio; and

(c) Any additional data or information requested by the commissioner.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 10-01-118 (Matter No. R 2009-04), § 284-44A-060, filed 12/17/09, effective 1/17/10.]

WAC 284-44A-070 The commissioner may reject filings. (1) The commissioner may reject and close any filing that does not comply with WAC 284-44A-040, 284-44A-050, or 284-44A-060. If the commissioner rejects a filing, the filer has not filed forms or rates with the commissioner.

(2) If the commissioner rejects a filing and the filer resubmits it as a new filing, the date filed will be the date the commissioner receives and accepts the new filing.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 10-01-118 (Matter No. R 2009-04), § 284-44A-070, filed 12/17/09, effective 1/17/10.]

WAC 284-44A-080 Filing authorization rules. A HCSC may authorize a third-party filer to file forms or rates on its behalf. For the purposes of this section, a "third-party filer" means a person or entity in the business of providing regulatory compliance services.

(1) If an HCSC delegates filing authority to a third-party filer, each filing must include a letter as supporting documentation signed by an officer of the HCSC authorizing the third-party filer to make filings on behalf of the HCSC.

(2) The HCSC may not delegate responsibility for the content of a filing to a third-party filer. The commissioner considers errors and omissions made by the third-party filer to be errors and omissions of the HCSC.

(3) If a third-party filer has a pattern of making filings that do not comply with this chapter, the commissioner may reject a delegation of filing authority from the HCSC.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 10-01-118 (Matter No. R 2009-04), § 284-44A-080, filed 12/17/09, effective 1/17/10.]

WAC 284-44A-090 Rules for responding to an objection letter. An objection letter may ask the filer to revise a noncompliant form or rate filing or provide clarification or additional information. The objection letter will state the reason(s) for disapproval, including relevant case law, statutes and rules. Filers must:

(1) Provide a complete response to an objection letter. A complete response must include:

(a) A separate response to each objection, and if appropriate;

(b) A description of changes proposed to noncompliant forms, and a replacement form attached to the form schedule; or

(c) Revised exhibits and supporting documentation.

(2) Respond to the commissioner in a timely manner.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 10-01-118 (Matter No. R 2009-04), § 284-44A-090, filed 12/17/09, effective 1/17/10.]

WAC 284-44A-100 Rules for revised or replaced forms. If an HCSC files a revised or replaced form, the filer must provide the supporting documentation described below:

(1) If a form is revised due to an objection(s) from the commissioner, the filer must provide a detailed explanation of all material changes to the disapproved form.

(2) If a form which received final action is replaced with a new version, the filer must submit an exhibit that marks and identifies each change or revision to the replaced form using one of these methods:

(a) A draft form that strikes through deletions and underlines additions or changes in the form;

(b) A draft form that includes comments in the margins explaining the changes in the form; or

(c) A side-by-side comparison of current and proposed language.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 10-01-118 (Matter No. R 2009-04), § 284-44A-100, filed 12/17/09, effective 1/17/10.]

WAC 284-44A-110 Effective date rules. (1) Filers must include a common implementation date for all forms or rates submitted in a filing.

(2) Filers may submit a request to change the implementation date of a filing as a note to reviewer.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 10-01-118 (Matter No. R 2009-04), § 284-44A-110, filed 12/17/09, effective 1/17/10.]

WAC 284-44A-120 Rules that apply to forms translated from English to another language. HCSCs may issue forms written in languages other than English.

(1) If the HCSC translates the form from English to another language, the HCSC must:

(a) File the translated version of the form.

(b) Include written disclosure statements on the translated contract indicating that it is issuing the translated form on an informational basis and the English version is controlling for the purposes of application and interpretation. The disclosure statements must be in English and the language of the translated form and printed in bold face type of at least twelve-point font.

(c) Submit a certification with the filing by an officer employed by the HCSC that they will issue the English version of the form with the translated form.

(2) When filing a translated form, the filer must:

(a) Identify the approved English version of the form by providing, as applicable, the:

(i) SERFF filing number;

(ii) Form number, edition date or edition identifier; and

(iii) Effective date of the filing.

(b) Submit certification by a professional translator certified by the American Translators Association or a comparable organization that the:

(i) Translator has translated the English version of the form; and

(ii) Translation is accurate.

(3) The commissioner will file but not review or approve translated form.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 10-01-118 (Matter No. R 2009-04), § 284-44A-120, filed 12/17/09, effective 1/17/10.]

Chapter 284-46 WAC

HEALTH MAINTENANCE ORGANIZATIONS

WAC

WAC 284-46-015 Discretionary clauses prohibited. (1) No contract may contain a discretionary clause. "Discretionary clause" means a provision that purports to reserve discretion to a health maintenance organization, its agents, officers, employees, or designees in interpreting the terms of a contract or deciding eligibility for benefits, or requires deference to such interpretations or decisions, including a provision that provides for any of the following results:

(a) That the carrier's interpretation of the terms of the contract is binding;

(b) That the carrier's decision regarding eligibility or continued receipt of benefits is binding;

(c) That the carrier's decision to deny, modify, reduce or terminate payment, coverage, authorization, or provision of health care service or benefits, is binding;

(d) That there is no appeal or judicial remedy from a denial of a claim;

(e) That deference must be given to the carrier's interpretation of the contract or claim decision; and

(f) That the standard of review of a carrier's interpretation of the contract or claim decision is other than a de novo review.

(2) Nothing in this section prohibits a carrier from including a provision in a contract that informs an insured that as part of its routine operations the carrier applies the terms of its contracts for making decisions, including making determination regarding eligibility, receipt of benefits and claims, or explaining its policies, procedures, and processes.

[Statutory Authority: RCW 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.200, 48.02.060, 48.18.110, 48.44.020, and 48.46.060. 09-16-128 (Matter No. R 2008-25), § 284-46-015, filed 8/5/09, effective 9/5/09.]

Chapter 284-46A WAC

HEALTH MAINTENANCE ORGANIZATION GENERAL RULES FOR ELECTRONIC FILING OF FORMS AND RATES IN SERFF

WAC

WAC 284-46A-010 Definitions that apply to this chapter. The definitions in this section apply throughout this chapter.

(1) "Complete filing" means a package of information containing forms, supporting information, documents and exhibits submitted to the commissioner electronically using the system for electronic rate and form filing (SERFF).

(2) "Date filed" means the date a complete filing has been received and accepted by the commissioner.

(3) "Filer" means:

(a) A person, organization or other entity that files forms or rates with the commissioner for an HMO; or

(b) A person employed by the HMO to file under this chapter.

(4) "Form" means a:

(a) "Contract" as defined in WAC 284-43-910; and includes:

(i) Applications;

(ii) Certificates of coverage;

(iii) Disclosure forms;

(iv) Enrollment forms;

(v) Policy forms, including riders;

(vi) Termination notice forms;

(vii) Short form filing summary, as outlined in the SERFF filing instructions; and

(viii) All other forms that are part of the contract.

(b) "Contract form" as defined in WAC 284-43-910;

(c) Network enrollment forms described in WAC 284-43-220(2);

(d) Prepayment agreements described in RCW 48.46.-060;

(e) Participating provider agreements as required by RCW 48.46.243; and

(f) Medicare supplement forms required to be filed under chapter 48.66 RCW.

(5) "Health maintenance organization" or "HMO" means the same as in RCW 48.46.020.

(6) "NAIC" means the National Association of Insurance Commissioners.

(7) "Objection letter" means correspondence created in SERFF and sent by the commissioner to the filer that:

(a) Requests clarification, documentation or other information;

(b) Explains errors or omissions in the filing; or

(c) Disapproves a form under RCW 48.46.060 or 48.46.243.

(8) "Rate" or "rates" means all classification manuals, rate manuals, rating schedules, class rates, and rating rules that must be filed under RCW 48.46.060 or 48.66.035.

(9) "Rate schedule" means the same as in WAC 284-43-910.

(10) "SERFF" means the system for electronic rate and form filing. SERFF is a proprietary NAIC computer-based application that allows insurers and other entities to create and submit rate, rule and form filings electronically to the commissioner.

(11) "Type of insurance" or "TOI" means a specific type of health care coverage listed in the *Uniform Life, Accident and Health, Annuity and Credit Coding Matrix* published by the NAIC and available at www.naic.org.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 10-01-118 (Matter No. R 2009-04), § 284-46A-010, filed 12/17/09, effective 1/17/10.]

WAC 284-46A-020 Purpose of this chapter. The purpose of this chapter is to:

(1) Adopt processes and procedures for filers and HMOs to use when submitting electronic forms and rates to the commissioner by way of SERFF.

(2) Effective July 1, 2010, designate SERFF as the method by which filers and HMOs must submit all forms and rates to the commissioner.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 10-01-118 (Matter No. R 2009-04), § 284-46A-020, filed 12/17/09, effective 1/17/10.]

WAC 284-46A-030 Scope of this chapter. This chapter applies to all HMOs that must file forms and rates under RCW 48.46.060, 48.46.243, and 48.66.035.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 10-01-118 (Matter No. R 2009-04), § 284-46A-030, filed 12/17/09, effective 1/17/10.]

WAC 284-46A-040 Filing instructions that are incorporated into this chapter. SERFF is a dynamic application that the NAIC will revise and enhance over time. To be consistent with NAIC filing standards and provide timely instructions to filers, the commissioner will incorporate documents posted on the SERFF web site into this chapter. By reference, the commissioner incorporates these documents into this chapter:

(1) The *SERFF Industry Manual* posted on the SERFF web site (www.serff.com); and

(2) The *Washington State SERFF Health and Disability Rate and Form Filing General Instructions* posted on the commissioner's web site (www.insurance.wa.gov).

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 10-01-118 (Matter No. R 2009-04), § 284-46A-040, filed 12/17/09, effective 1/17/10.]

WAC 284-46A-050 General form and rate filing rules. (1) Each form or rate filing must be submitted to the commissioner electronically using SERFF.

(a) Every form filed in SERFF must:

(i) Be attached to the form schedule; and

(ii) Have a unique identifying number and a way to distinguish it from other versions of the same form.

(b) Filers must send all written correspondence related to a form or rate filing in SERFF.

(2) All filed forms must be legible for both the commissioner's review and retention as a public record. Filers must submit new or revised forms to the commissioner for review in final form displayed in ten-point or larger type.

(3) Filers must submit complete filings that comply with the *SERFF Industry Manual* posted on the SERFF web site (www.serff.com) and the *Washington State Health and Disability Form Filing General Instructions* posted on the commissioner's web site (www.insurance.wa.gov).

(4) Filers must submit separate filings for each type of insurance.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 10-01-118 (Matter No. R 2009-04), § 284-46A-050, filed 12/17/09, effective 1/17/10.]

WAC 284-46A-060 Specific rate filing rules. (1) If a rate filing is required under RCW 48.46.060, or 48.66.035, the filer must submit it:

(a) Separate from any corresponding form filing; and

(b) Concurrently with the corresponding form filing if new forms are being introduced.

(2) Each rate filing must include, if appropriate:

(a) Rates schedules;

(b) Actuarial data that supports the:

(i) Proposed rate schedules; and

(ii) Anticipated loss ratio; and

(c) Any additional data or information requested by the commissioner.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 10-01-118 (Matter No. R 2009-04), § 284-46A-060, filed 12/17/09, effective 1/17/10.]

WAC 284-46A-070 The commissioner may reject filings. (1) The commissioner may reject and close any filing that does not comply with WAC 284-46A-040, 284-46A-050, or 284-46A-060. If the commissioner rejects a filing, the filer has not filed forms or rates with the commissioner.

(2) If the commissioner rejects a filing and the filer resubmits it as a new filing, the date filed will be the date the commissioner receives and accepts the new filing.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 10-01-118 (Matter No. R 2009-04), § 284-46A-070, filed 12/17/09, effective 1/17/10.]

WAC 284-46A-080 Filing authorization rules. An HMO may authorize a third-party filer to file forms or rates on its behalf. For the purposes of this section, a "third-party filer" means a person or entity in the business of providing regulatory compliance services.

(1) If an HMO delegates filing authority to a third-party filer, each filing must include a letter as supporting documen-

tation signed by an officer of the HMO authorizing the third-party filer to make filings on behalf of the HMO.

(2) The HMO may not delegate responsibility for the content of a filing to a third-party filer. The commissioner considers errors and omissions made by the third-party filer to be errors and omissions of the HMO.

(3) If a third-party filer has a pattern of making filings that do not comply with this chapter, the commissioner may reject a delegation of filing authority from the HMO.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 10-01-118 (Matter No. R 2009-04), § 284-46A-080, filed 12/17/09, effective 1/17/10.]

WAC 284-46A-090 Rules for responding to an objection letter. An objection letter may ask the filer to revise a noncompliant form or rate filing or provide clarification or additional information. The objection letter will state the reason(s) for disapproval, including relevant case law, statutes and rules. Filers must:

(1) Provide a complete response to an objection letter. A complete response must include:

(a) A separate response to each objection, and if appropriate;

(b) A description of changes proposed to noncompliant forms, and a replacement form attached to the form schedule; or

(c) Revised exhibits and supporting documentation.

(2) Respond to the commissioner in a timely manner.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 10-01-118 (Matter No. R 2009-04), § 284-46A-090, filed 12/17/09, effective 1/17/10.]

WAC 284-46A-100 Rules for revised or replaced forms. If an HMO files a revised or replaced form, the filer must provide the supporting documentation described below:

(1) If a form is revised due to an objection(s) from the commissioner, the filer must provide a detailed explanation of all material changes to the disapproved form.

(2) If a form which received final action is replaced with a new version, the filer must submit an exhibit that marks and identifies each change or revision to the replaced form using one of these methods:

(a) A draft form that strikes through deletions and underlines additions or changes in the form;

(b) A draft form that includes comments in the margins explaining the changes in the form; or

(c) A side-by-side comparison of current and proposed language.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 10-01-118 (Matter No. R 2009-04), § 284-46A-100, filed 12/17/09, effective 1/17/10.]

WAC 284-46A-110 Effective date rules. (1) Filers must include a common implementation date for all forms or rates submitted in a filing.

(2) Filers may submit a request to change the implementation date of a filing as a note to reviewer.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 10-01-118 (Matter No. R 2009-04), § 284-46A-110, filed 12/17/09, effective 1/17/10.]

WAC 284-46A-120 Rules that apply to forms translated from English to another language. HMOs may issue forms written in languages other than English.

(1) If the HMO translates the form from English to another language, the HMO must:

(a) File the translated version of the form.

(b) Include written disclosure statements on the translated contract indicating that it is issuing the translated form on an informational basis and the English version is controlling for the purposes of application and interpretation. The disclosure statements must be in English and the language of the translated form and printed in bold face type of at least twelve-point font.

(c) Submit a certification with the filing by an officer employed by the HMO that they will issue the English version of the form with the translated form.

(2) When filing a translated form, the filer must:

(a) Identify the approved English version of the form by providing, as applicable, the:

(i) SERFF filing number;

(ii) Form number, edition date or edition identifier; and

(iii) Effective date of the filing.

(b) Submit certification by a professional translator certified by the American Translators Association or a comparable organization that the:

(i) Translator has translated the English version of the form; and

(ii) Translation is accurate.

(3) The commissioner will file but not review or approve translated form.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 10-01-118 (Matter No. R 2009-04), § 284-46A-120, filed 12/17/09, effective 1/17/10.]

Chapter 284-50 WAC

WASHINGTON DISABILITY INSURANCE REGULATIONS

WAC

WAC 284-50-321 Discretionary clauses prohibited. (1) No disability insurance policy may contain a discretionary clause. "Discretionary clause" means a provision that purports to reserve discretion to an insurer, its agents, officers, employees, or designees in interpreting the terms of a policy or deciding eligibility for benefits, or requires deference to such interpretations or decisions, including a provision that provides for any of the following results:

(a) That the insurer's interpretation of the terms of the policy is binding;

(b) That the insurer's decision regarding eligibility or continued receipt of benefits is binding;

(c) That the insurer's decision to deny, modify, reduce or terminate payment, coverage, authorization, or provision of health care service or benefits, is binding;

(d) That there is no appeal or judicial remedy from a denial of a claim;

(e) That deference must be given to the insurer's interpretation of the contract or claim decision; and

(f) That the standard of review of an insurer's interpretation of the policy or claim decision is other than a de novo review.

(2) Nothing in this section prohibits an insurer from including a provision in a policy that informs an insured that

as part of its routine operations the insurer applies the terms of its policies for making decisions, including making determination regarding eligibility, receipt of benefits and claims, or explaining its policies, procedures, and processes.

[Statutory Authority: RCW 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.200, 48.02.060, 48.18.110, 48.44.020, and 48.46.060. 09-16-128 (Matter No. R 2008-25), § 284-50-321, filed 8/5/09, effective 9/5/09.]

Chapter 284-51 WAC
STANDARDS FOR COORDINATION OF BENEFITS

WAC

WAC 284-51-195 Definitions. As used in this chapter, these words and terms have the following meanings, unless the context clearly indicates otherwise:

(1) "Allowable expense," except as outlined below means any health care expense, including coinsurance or copayments and without reduction for any applicable deductible, that is covered in full or in part by any of the plans covering the person. When coordinating benefits, any secondary plans must pay an amount which, together with the payment made by the primary plan, totals the higher of the allowable expenses. In no event will a secondary plan be required to pay an amount in excess of its maximum benefit plus accrued savings. When medicare, Part A and Part B or Part C are primary, medicare's allowable amount is the highest allowable expense.

(a) If an issuer is advised by a covered person that all plans covering the person are high-deductible health plans and the person intends to contribute to a health savings account established according to Section 223 of the Internal Revenue Code of 1986, the primary high-deductible health plan's deductible is not an allowable expense, except for any health care expense incurred that may not be subject to the deductible as described in Section 223 (c)(2)(C) of the Internal Revenue Code of 1986.

(b) An expense or a portion of an expense that is not covered by any of the plans is not an allowable expense.

(c) The following are examples of expenses that are not allowable expenses:

(i) If a person is confined in a private hospital room, the difference between the cost of a semiprivate room in the hospital and the private room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

(ii) If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement method, any amount charged by the provider in excess of the highest reimbursement amount for a specified benefit is not an allowable expense.

(iii) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.

(d) The definition of "allowable expense" may exclude certain types of coverage or benefits such as dental care, vision care, prescription drugs or hearing aids. A plan that limits the application of COB to certain coverages or benefits may limit the definition of allowable expense in its contract to expenses that are similar to the expenses that it provides. When COB is restricted to specific coverages or benefits in a contract, the definition of allowable expense must include similar expenses to which COB applies.

(e) When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.

(f) If a secondary plan has been informed of the payment made by the primary plan but has not been informed of the amount of the primary plan's allowable expense within the period set forth in WAC 284-51-215 (2)(c), the secondary plan may use its allowable expense as the highest allowable expense.

(2) "Birthday" refers only to the month and day in a calendar year and does not include the year in which the individual is born.

(3) "Claim" means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of:

(a) Services (including supplies);

(b) Payment for all or a portion of the expenses incurred;

(c) A combination of (a) and (b) of this subsection; or

(d) An indemnification.

(4) "Claim determination period" means calendar year.

(5) "Closed panel plan" means a plan that provides health benefits to covered persons in the form of services primarily through a panel of providers that are employed by the plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

(6) "Consolidated Omnibus Budget Reconciliation Act of 1985" or "COBRA" means coverage provided under a right of continuation according to federal law.

(7) "Coordination of benefits" or "COB" means a provision establishing the order that plans pay their claims, and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

(8) "Custodial parent" means:

(a) The parent awarded custody of a child by a court decree; or

(b) In the absence of a court decree, the parent with whom the child resides more than one-half of the calendar year without regard to any temporary visitation; or

(c) In cases where a court decree awards more than half of the calendar year's residential time to one parent without the use of "custodial" terminology, the parent to whom the greater residential time is awarded.

(9) "High-deductible health plan" has the meaning given the term under Section 223 of the Internal Revenue Code of 1986, as amended by the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

(10)(a) "Hospital indemnity benefits" or "hospital fixed payment plan" means benefits not related to expenses incurred.

(b) "Hospital indemnity benefits" or "hospital fixed payment plan" does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

(11) "Issuer" means a disability carrier, health care service contractor, health maintenance organization, and any other entity issuing a plan as defined in this chapter.

(12) "Plan" means a form of coverage with which coordination is allowed. Separate parts of a plan for members of a group that are provided through alternative contracts that are intended to be part of a coordinated package of benefits are considered one plan and there is no COB among the separate parts of the plan.

(a) If a plan coordinates benefits, its contract must state the types of coverage that will be considered in applying the COB provision of that contract. Whether the contract uses the term "plan" or some other term such as "program," the contractual definition may be no broader than the definition of "plan" in this subsection.

(b) "Plan" includes:

(i) Group, individual or blanket disability insurance contracts, and group or individual contracts marketed by issuers as defined in this chapter;

(ii) Closed panel plans or other forms of group or individual coverage;

(iii) The medical care components of long-term care contracts, such as skilled nursing care; and

(iv) Medicare or other governmental benefits, as permitted by law, except as provided in (c)(vii) of this subsection. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program.

(c) "Plan" does not include:

(i) Hospital indemnity or fixed payment coverage benefits or other fixed indemnity or payment coverage;

(ii) Accident only coverage;

(iii) Specified disease or specified accident coverage;

(iv) Limited benefit health coverage, as defined in WAC 284-50-370;

(v) School accident and similar coverages that cover students for accidents only, including athletic injuries, either on a twenty-four-hour basis or on a "to and from school" basis;

(vi) Benefits provided in long-term care insurance policies for nonmedical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;

(vii) Medicare supplement policies;

(viii) A state plan under medicaid;

(ix) A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan;

(x) Automobile insurance policies required by statute to provide medical benefits;

(xi) Benefits provided as part of a direct agreement with a direct patient-provider primary care practice as defined at section 3, chapter 267, Laws of 2007.

(13) "Policyholder" means the primary insured named in a nongroup insurance policy.

(14) "Primary plan" means a plan whose benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration. A plan subject to this chapter is a primary plan if:

(a) The plan either has no order of benefit determination rules, or its rules differ from those permitted by this chapter; or

(b) All plans that cover the person use the order of benefit determination rules required by this chapter, and under those rules the plan determines its benefits first.

(15) "Secondary plan" means a plan that is not a primary plan.

[Statutory Authority: RCW 48.02.060, 48.21.200, 48.44.050, and 48.46.200. 09-16-073 (Matter No. R 2008-20), § 284-51-195, filed 7/30/09, effective 9/1/09; 07-13-008 (Matter No. R 2005-07), § 284-51-195, filed 6/8/07, effective 7/9/07.]

WAC 284-51-215 Time limit. (1) Each issuer must establish time limits for payment of a claim and may not unreasonably delay payment through the application of a coordination of benefits provision. Time limits established by a primary plan must be no less favorable than those contained in WAC 284-43-321. Primary plans must pay ninety-five percent of clean claims subject to this chapter within thirty calendar days of receipt or of determining they are the primary plan, and must pay all clean claims subject to this chapter within sixty calendar days of receipt or of determining they are the primary plan. Any time limit established by a secondary plan that is in excess of thirty days from receipt of a claim, with the primary plan's explanation of benefit information or other primary payment details needed to process the claim, will be considered unreasonable. The deadlines established in this subsection may be extended for the length of time a primary or secondary plan must wait for information needed from the provider (e.g., medical records) or from the enrollee (e.g., motor vehicle accident information), in order to adjudicate the claim.

(2) The specific time limits for coordination of benefits processing include:

(a) When an issuer has been notified that more than one plan covers an enrollee who has submitted a claim, the issuer shall resolve with the other plan in not more than thirty calendar days which plan is primary. This deadline may be extended in situations involving court orders for dependent coverage, if the court order contains information needed to determine which plan is primary and has not been provided to the issuer. If agreement cannot be reached, both plans shall pay as set forth in WAC 284-51-205 (4)(f).

(b) Once the primary plan and secondary plan have been established, if the secondary plan receives a claim without the primary plan's explanation of benefit information or other primary payment details needed to process the claim, including at least the paid amount and the allowed amount, the secondary plan will notify the submitting provider and/or enrollee as soon as possible and within thirty calendar days of receipt of the claim, that the secondary claim is incomplete without such primary plan information. The secondary plan will promptly process the claim after it has been resubmitted with the explanation of benefit information from the primary payer.

(c) If a primary plan has not adjudicated a claim within sixty calendar days of receipt of the claim and all supporting documentation, and if the primary plan is not waiting for information from the provider (e.g., medical records) or from the enrollee (e.g., motor vehicle accident information),

needed to adjudicate the claim, the provider or enrollee may submit the claim and notice of the primary plan's failure to pay to the secondary plan which shall pay the provider's claim as primary within thirty calendar days.

(3) When payment is necessarily delayed for reasons other than the application of a coordination of benefits provision, investigation of other plan coverage must be conducted concurrently to avoid delay in the ultimate payment of benefits. Any issuer that is required by the time limit in subsection (2) of this section to make payment as the primary plan may exercise its rights under its "right of recovery" provision for recovery of any excess payments. After payment information is received from the primary plan, the secondary plan may recover any excess amount paid under its "right of recovery" provision.

(4) The provisions in this section do not apply when medicare is the primary payer; in such cases federal medicare law governs.

[Statutory Authority: RCW 48.02.060, 48.21.200, 48.44.050, and 48.46.-200. 09-16-073 (Matter No. R 2008-20), § 284-51-215, filed 7/30/09, effective 9/1/09; 07-13-008 (Matter No. R 2005-07), § 284-51-215, filed 6/8/07, effective 7/9/07.]

WAC 284-51-235 Notice to covered persons. A plan must include the following statement in the enrollee contract or booklet provided to covered persons:

"If you are covered by more than one health benefit plan, and you do not know which is your primary plan, you or your provider should contact any one of the health plans to verify which plan is primary. The health plan you contact is responsible for working with the other plan to determine which is primary and will let you know within thirty calendar days.

CAUTION: All health plans have timely claim filing requirements. If you or your provider fail to submit your claim to a secondary health plan within that plan's claim filing time limit, the plan can deny the claim. If you experience delays in the processing of your claim by the primary health plan, you or your provider will need to submit your claim to the secondary health plan within its claim filing time limit to prevent a denial of the claim.

To avoid delays in claims processing, if you are covered by more than one plan you should promptly report to your providers and plans any changes in your coverage."

[Statutory Authority: RCW 48.02.060, 48.21.200, 48.44.050, and 48.46.-200. 09-16-073 (Matter No. R 2008-20), § 284-51-235, filed 7/30/09, effective 9/1/09; 07-13-008 (Matter No. R 2005-07), § 284-51-235, filed 6/8/07, effective 7/9/07.]

WAC 284-51-260 Appendix B—Consumer explanatory booklet.

COORDINATION OF BENEFITS

IMPORTANT NOTICE

This is a summary of only a few of the provisions of your health plan to help you understand coordination of benefits, which can be very complicated. This is not a complete description of all of the coordination rules and procedures, and does not change or replace the language contained in your insurance contract, which determines your benefits.

Double Coverage

It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers.

When you are covered by more than one health plan, state law permits issuers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses.

Coordination of benefits (COB) is complicated, and covers a wide variety of circumstances. This is only an outline of some of the most common ones. If your situation is not described, read your evidence of coverage or contact your state insurance department.

Primary or Secondary?

You will be asked to identify all the plans that cover members of your family. To avoid delays in claim processing, if you are covered by more than one plan you should promptly report to your providers and plans any changes in your coverage. We need this information to determine whether we are the "primary" or "secondary" benefit payer. The primary plan always pays first when you have a claim.

Any plan that does not contain your state's COB rules will always be primary.

When This Plan is Primary

If you or a family member is covered under another plan in addition to this one, we will be primary when:

Your Own Expenses

• The claim is for your own health care expenses, unless you are covered by medicare and both you and your spouse are retired.

Your Spouse's Expenses

• The claim is for your spouse, who is covered by medicare, and you are not both retired.

• **Your child's expenses.** The claim is for the health care expenses of your child who is covered by this plan; and

• You are married and your birthday is earlier in the year than your spouse's or you are living with another individual, regardless of whether or not you have ever been married to that individual, and your birthday is earlier than that other individual's birthday. This is known as the "birthday rule"; or

• You are separated or divorced and you have informed us of a court decree that makes you responsible for the child's health care expenses; or

• There is no court decree, but you have custody of the child.

Other Situations

We will be primary when any other provisions of state or federal law require us to be.

How We Pay Claims When We Are Primary

When we are the primary plan, we will pay the benefits according to the terms of your contract, just as if you had no other health care coverage under any other plan.

How We Pay Claims When We Are Secondary

When we are knowingly the secondary plan, we will make payment promptly after receiving payment information from your primary plan. Your primary plan, and we as your secondary plan, may ask you and/or your provider for information in order to make payment. To expedite payment, be sure that you and/or your provider supply the information in a timely manner.

If the primary plan fails to pay within sixty calendar days of receiving all necessary information from you and your provider, you and/or your provider may submit your claim for us to make payment as if we were your primary plan. In such situations, we are required to pay claims within thirty calendar days of receiving your claim and the notice that your primary plan has not paid. This provision does not apply if medicare is the primary plan. We may recover from the primary plan any excess amount paid under the "right of recovery" provision in the plan.

• If there is a difference between the amounts the plans allow, we will base our payment on the higher amount. However, if the primary plan has a contract with the provider, our combined payments will not be more than the amount called for in our contract or the amount called for in the contract of the primary plan, whichever is higher. Health maintenance organizations (HMOs) and health care service contractors usually have contracts with their providers as do some other plans.

• We will determine our payment by subtracting the amount paid by the primary plan from the amount we would have paid if we had been primary. We must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal to one hundred percent of the total allowable expense (the highest of the amounts allowed under each plan involved) for your claim. We are not required to pay an amount in excess of our maximum benefit plus any accrued savings. If your provider negotiates reimbursement amounts with the plan(s) for the service provided, your provider may not bill you for any excess amounts once he/she has received payment for the highest of the negotiated amounts. When our deductible is fully credited, we will place any remaining amounts in a savings account to cover future claims which might not otherwise have been paid. For example, if the primary plan covers similar kinds of health care expenses, but allows expenses that we do not cover, we may pay for those expenses.

Questions About Coordination of Benefits? Contact Your State Insurance Department

[Statutory Authority: RCW 48.02.060, 48.21.200, 48.44.050, and 48.46.200. 09-16-073 (Matter No. R 2008-20), § 284-51-260, filed 7/30/09, effective 9/1/09; 07-13-008 (Matter No. R 2005-07), § 284-51-260, filed 6/8/07, effective 7/9/07.]

Chapter 284-53 WAC

STANDARDS FOR COVERAGE OF CHEMICAL DEPENDENCY

WAC

WAC 284-53-005 Definitions. (1) "Approved treatment program" means a discrete program of chemical dependency treatment provided by a treatment program certified by the department of social and health services as meeting standards adopted under chapter 70.96A RCW.

(2) "Chemical dependency" means the illness as defined in RCW 48.21.195.

(3) "Chemical dependency professional" means a person certified as a chemical dependency professional by the Washington state department of health under chapter 18.205 RCW.

(4) "Cost sharing" includes deductibles, copayments, coinsurance and out-of-pocket expenses.

(5) "Emergency medical condition" means the condition as defined in RCW 48.43.005.

(6) "Medically necessary" or "medical necessity," with respect to chemical dependency coverage is defined by the American Society of Addiction Medicine patient placement criteria. "Patient placement criteria" means the admission, continued service, and discharge criteria set forth in the most recent version of the *Patient Placement Criteria for the Treatment of Substance Abuse-Related Disorders* as published by the American Society of Addiction Medicine.

(7) "Substance use disorder" as used in P.L. 110-343 (October 3, 2008) as currently enacted or hereafter amended (short title: The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008) includes those conditions meeting the definition of chemical dependency in RCW 48.21.195, 48.44.245, and 48.46.355.

(8) "Treatment limitation" includes limits on the frequency of treatment, number of visits, days of coverage, waiting periods, or other similar limits on the scope or duration of treatment.

[Statutory Authority: RCW 48.02.060, 48.21.197, and Mental Health Parity and Addiction Equity Act of 2008, Pub. L No 110-343 (Oct. 3, 2008). 09-15-023 (Matter No. R 2008-27), § 284-53-005, filed 7/7/09, effective 8/7/09. Statutory Authority: RCW 48.02.060, 48.21.197, 48.44.050, and 48.46.200. 04-22-051 (Matter No. R 2003-08), § 284-53-005, filed 10/28/04, effective 11/28/04. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.21.160, 48.21.180, 48.21.197, 48.44.240 and 48.46.350. 99-16-005 (Matter No. R 97-8), § 284-53-005, filed 7/22/99, effective 8/22/99.]

WAC 284-53-010 Standards for coverage of chemical dependency. Effective January 1, 2010, group health benefit plans providing chemical dependency benefits required by RCW 48.21.180, 48.44.240, or 48.46.350 must meet the following standards and administrative requirements:

(1) Any group contract providing coverage for chemical dependency benefits must define "chemical dependency" consistent with definitions in Title 48 RCW and this chapter.

(2) Coverage for chemical dependency benefits must include payment for reasonable charges for any medically necessary treatment and supporting service rendered to an enrollee by an approved treatment program.

(3) Cost sharing amounts for chemical dependency services may be no more than the cost sharing amounts for medical and surgical services otherwise provided under the health benefit plan. Cost sharing amounts must not be separate from those for medical and surgical benefits covered by the plan.

(4) Lifetime limits must apply to chemical dependency benefits in the same manner as medical and surgical benefits.

(5) Treatment limitation for chemical dependency services is allowed only if the same limitation or requirement is imposed on coverage for medical and surgical services. Benefits for actual treatment and services rendered may not be denied solely because a course of treatment was interrupted or was not completed.

(6) Medically necessary detoxification must be covered as an emergency medical condition according to RCW 48.43.093, and may be provided in hospitals licensed under chapter 70.41 RCW. Medically necessary detoxification services must not require prenotification, and may not be included when calculating payments within the chemical dependency payment minimum required in this chapter, as long as the enrollee is not yet enrolled in other chemical dependency treatment.

(7) Carriers who provide benefits through a defined network must meet the network adequacy requirements set forth in WAC 284-43-200. Health benefit plans that allow for out-of-network benefits must apply them to chemical dependency services consistent with medical and surgical benefits.

(8)(a) In certain circumstances, the carrier may require the enrollee to provide an initial assessment of the need for chemical dependency treatment and a treatment plan prior to scheduled treatment. The assessment may be at the enrollee's expense and must be provided no less than ten and no more than thirty working days before treatment is to begin. The circumstances are:

(i) Where an enrollee is court ordered to undergo a chemical dependency assessment or treatment;

(ii) Situations related to deferral of prosecution, deferral of sentencing or suspended sentencing; or

(iii) Situations pertaining to motor vehicle driving rights and the Washington state department of licensing.

(b) For the initial assessment in (a) of this subsection, the enrollee may choose any individual that is:

(i) Certified as a chemical dependency professional; and

(ii) Employed by an approved treatment program.

(c) Nothing in this chapter requires a carrier to pay for court ordered chemical dependency treatment that is not medically necessary, or relieves a carrier from its obligations to pay for court ordered chemical dependency treatment when it is medically necessary.

(9) Unless chemical dependency treatment is determined not to be medically necessary, or except as otherwise specifically provided in this chapter, contractual provisions may not restrict access to treatment, continuity of care or payment of claims.

(10)(a) The minimum benefit for chemical dependency treatment and supporting services, exclusive of all cost sharing amounts in any consecutive twenty-four-month period must be as follows:

(i) For contracts issued or renewed January 1, 2010, through December 31, 2010, the benefit must not be less than fifteen thousand dollars.

(ii) Each succeeding year from January 1, 2011, through December 31, 2015, the benefit must increase in increments of not less than five hundred dollars for new and renewing contracts.

(b) By January 1, 2015, the commissioner must begin a technical review that includes the actual and projected costs of the benefits and the consumer price index to establish the future minimum benefits for the five-year period beginning January 1, 2016. The commissioner must publish the new minimum benefit amounts by June 30, 2015.

[Statutory Authority: RCW 48.02.060, 48.21.197, and Mental Health Parity and Addiction Equity Act of 2008, Pub. L No 110-343 (Oct. 3, 2008). 09-15-023 (Matter No. R 2008-27), § 284-53-010, filed 7/7/09, effective 8/7/09. Statutory Authority: RCW 48.02.060, 48.21.197, 48.44.050, and 48.46.200. 04-22-051 (Matter No. R 2003-08), § 284-53-010, filed 10/28/04, effective 11/28/04. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.21.160, 48.21.180, 48.21.197, 48.44.240 and 48.46.350. 99-16-005 (Matter No. R 97-8), § 284-53-010, filed 7/22/99, effective 8/22/99. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 87-18-050 (Order R 87-10), § 284-53-010, filed 8/31/87, effective 1/1/88; 86-18-027 (Order R 86-2), § 284-53-010, filed 8/27/86, effective 1/1/87.]

Chapter 284-66 WAC

WASHINGTON MEDICARE SUPPLEMENT INSURANCE REGULATION

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-66-092	Form of "outline of coverage." [Statutory Authority: RCW 48.06.060 and 48.66.165. 07-06-014 (Matter No. R 2006-13), § 284-66-092, filed 2/26/07, effective 3/29/07. Statutory Authority: RCW 48.02.060 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-092, filed 8/4/05, effective 9/4/05. Statutory Authority: RCW 48.02.060. 92-17-078 (Order R 92-7), § 284-66-092, filed 8/19/92, effective 9/19/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-092, filed 2/25/92, effective 3/27/92.] Repealed by 09-24-052 (Matter No. R 2009-08), filed 11/24/09, effective 1/19/10. Statutory Authority: RCW 48.66.030 (3)(a), 48.66.041, and 48.66.165.
284-66-247	Interim rate and form filing requirements for standardized plans H, I and J and prestandardized plans that include outpatient prescription drug benefits. [Statutory Authority: RCW 48.02.060 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-247, filed 8/4/05, effective 9/4/05.] Repealed by 09-24-052 (Matter No. R 2009-08), filed 11/24/09, effective 1/19/10. Statutory Authority: RCW 48.66.030 (3)(a), 48.66.041, and 48.66.165.

WAC 284-66-030 Definitions. For purposes of this chapter:

(1) "Applicant" means:

(a) In the case of an individual medicare supplement insurance policy, the person who seeks to contract for insurance benefits; and

(b) In the case of a group medicare supplement insurance policy, the proposed certificate holder.

(2) "Certificate" means any certificate delivered or issued for delivery in this state under a group medicare supplement insurance policy regardless of the situs of the group master policy.

(3) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

(4) "Issuer" includes insurance companies, fraternal benefit societies, health care service contractors, health maintenance organizations, and any other entity delivering or issuing for delivery medicare supplement policies or certificates.

(5) "Direct response issuer" means an issuer 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.

(6) "Disability insurance" is insurance against bodily injury, disablement or death by accident, against disablement resulting from sickness, and every insurance relating to disability insurance. For purposes of this chapter, disability insurance includes policies or contracts offered by any issuer.

(7) "Health care expense costs," for purposes of WAC 284-66-200(4), means expenses of a health maintenance organization or health care service contractor associated with the delivery of health care services that are analogous to incurred losses of insurers.

(8) "Policy" includes agreements or contracts issued by any issuer.

(9) "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

(10) "Premium" means 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 issuer in consideration for the policy is deemed part of the premium. "Earned premium" means the "premium" applicable to an accounting period whether received before, during or after that period.

(11) "Prestandardized medicare supplement benefit plan," "prestandardized benefit plan" or "prestandardized plan" means a group or individual policy of medicare supplement insurance issued prior to January 1, 1990.

(12) "Replacement" means any transaction where new medicare supplement coverage is to be purchased, and it is known or should be known to the proposing agent or other representative of the issuer, or to the proposing issuer if there is no agent, that by reason of the transaction, existing medicare supplement coverage has been or is to be lapsed, surrendered or otherwise terminated.

(13) "Secretary" means the Secretary of the United States Department of Health and Human Services.

(14) "1990 standardized medicare supplement benefit plan" means a group or individual policy of medicare supplement insurance issued on or after January 1, 1990, and prior to June 1, 2010, and includes medicare supplement insurance policies and certificates renewed on or after that date which are not replaced by the issuer at the request of the insured.

(15) "2010 standardized medicare supplement benefit plan" or "2010 plan" means a group or individual policy of medicare supplement insurance with an effective date for coverage on or after June 1, 2010.

[Statutory Authority: RCW 48.66.030 (3)(a), 48.66.041, and 48.66.165. 09-24-052 (Matter No. R 2009-08), § 284-66-030, filed 11/24/09, effective 1/19/10. Statutory Authority: RCW 48.02.060 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-030, filed 8/4/05, effective 9/4/05. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-030, filed 2/25/92, effective 3/27/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.-130, 48.46.200, 48.66.041, 48.66.050, 48.66.100, 48.66.110, 48.66.120, 48.66.130, 48.66.150 and 48.66.160. 90-07-059 (Order R 90-4), § 284-66-030, filed 3/20/90, effective 4/20/90.]

WAC 284-66-063 Benefit standards for policies or certificates issued or delivered after June 30, 1992 and before June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a medicare supplement policy or certificate unless it complies with these benefit standards.

(1) General standards. The following standards apply to medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

(a) A medicare supplement policy or certificate may not exclude or limit benefits for losses incurred more than three months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within three months before the effective date of coverage.

(b) A medicare supplement policy or certificate must provide that benefits designed to cover cost sharing amounts under medicare will be changed automatically to coincide with any changes in the applicable medicare deductible, copayment or coinsurance amounts. Premiums may be modified to correspond with such changes.

(c) A medicare supplement policy or certificate may 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.

(d) Each medicare supplement policy must be guaranteed renewable and:

(i) The issuer may not cancel or nonrenew the policy solely on the ground of health status of the individual; and

(ii) The issuer may not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(iii) If the medicare supplement policy is terminated by the group policyholder and is not replaced as provided under (d)(v) of this subsection, the issuer must offer certificate holders an individual medicare supplement policy that (at the option of the certificate holder) provides for continuation of the benefits contained in the group policy, or provides for benefits that otherwise meet the requirements of this subsection.

(iv) If an individual is a certificate holder in a group medicare supplement policy and the individual terminates membership in the group, the issuer must offer the certificate holder the conversion opportunity described in (c)(iii) of this subsection, or at the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(v) If a group medicare supplement policy is replaced by another group medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy must offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy may not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(e) Termination of a medicare supplement policy or certificate must be without prejudice to any continuous loss that began while the policy was in force, but the extension of benefits beyond the period that the policy was in force may be conditioned 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. Receipt of medicare Part D benefits will not be considered in determining a continuous loss.

(f) If a medicare supplement policy or certificate eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug Improvement and Modernization Act of 2003, the modified policy or certificate is deemed to satisfy the guaranteed renewal requirements of this section.

(g)(i) A medicare supplement policy or certificate must provide that benefits and premiums under the policy or certificate must be suspended at the request of the policyholder or certificate holder for the period (not to exceed twenty-four months) that the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within ninety days after the date the individual becomes entitled to the assistance.

(ii) If the suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate must be automatically reinstituted effective as of the date of termination of the entitlement if the policyholder or certificate holder provides notice of loss of the entitlement within ninety days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

(iii) Each medicare supplement policy must provide that benefits and premiums under the policy will be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy must be automatically reinstituted (effective as of the date of loss of coverage within ninety days after the date of the loss).

(h) Reinstitution of the coverages:

(i) May not provide for any waiting period with respect to treatment of preexisting conditions;

(ii) Must provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of the suspension. If the suspended medicare supplement policy or certificate provided coverage for outpatient prescription drugs, reinstitution of the policy for medicare Part D enrollees must be without coverage for outpatient prescription drugs and must otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and

(iii) Must provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

(2) If an issuer makes a written offer to the medicare supplement policyholders or certificate holders of one or more of its plans, to exchange his or her standardized plan to a 2010 standardized plan during a specified period, the offer and subsequent exchange must comply with the following requirements:

(a) An issuer need not provide justification to the commissioner if the insured replaces a 1990 standardized policy or certificate with a 2010 standardized policy or certificate.

(b) An issuer may not apply new preexisting condition limitations or a new incontestability period to the replacement policy for those benefits contained in the former exchanged policy or certificate of the insured, but may apply preexisting condition limitations of no more than three months to any benefits contained in the new 2010 standardized policy or certificate that were not contained in the former exchanged policy.

(c) The new policy or certificate must be offered to all policyholders or certificate holders within a given plan, except where the offer or issue would be in violation of state or federal law.

(3) Standards for basic ("core") benefits common to benefit plans A-J. Every issuer must make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other medicare supplement insurance benefit plans in addition to the basic "core" package, but not in place of the basic "core" package.

(a) 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;

(b) Coverage of Part A medicare eligible expenses incurred for hospitalization to the extent not covered by medicare for each medicare lifetime inpatient reserve day used;

(c) Upon exhaustion of the medicare hospital inpatient coverage including the lifetime reserve days, coverage of one hundred percent of the medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate or other appropriate medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five days. The provider must

accept the issuer's payment as payment in full and may not bill the insured for any balance;

(d) Coverage under medicare Parts A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

(e) Coverage for the coinsurance amount, or in the case of hospital; outpatient department services paid under a prospective payment system, the copayment amount, of medicare eligible expenses under Part B regardless of hospital confinement, subject to the medicare Part B deductible;

(4) Standards for additional benefits. The following additional benefits must be included in medicare supplement benefit plans "B" through "J" only as provided by WAC 284-66-066.

(a) Medicare Part A deductible: Coverage for all of the medicare Part A inpatient hospital deductible amount per benefit period.

(b) Skilled nursing facility care: Coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredth day in a medicare benefit period for posthospital skilled nursing facility care eligible under medicare Part A;

(c) Medicare Part B deductible: Coverage for all of the medicare Part B deductible amount per calendar year regardless of hospital confinement.

(d) Eighty percent of the medicare Part B excess charges: Coverage for eighty percent of the difference between the actual medicare Part B charge as billed, not to exceed any charge limitation established by the medicare program or state law, and the medicare-approved Part B charge.

(e) One hundred percent of the medicare Part B excess charges: Coverage for all of the difference between the actual medicare Part B charge as billed, not to exceed any charge limitation established by the medicare program or state law, and the medicare-approved Part B charge.

(f) Basic outpatient prescription drug benefit: Coverage for fifty percent of outpatient prescription drug charges, after a two hundred fifty dollar calendar year deductible, to a maximum of one thousand two hundred fifty dollars in benefits received by the insured per calendar year, to the extent not covered by medicare. The outpatient prescription drug benefit may not be included for sale or issuance in a medicare supplement policy after December 31, 2005.

(g) Extended outpatient prescription drug benefit: Coverage for fifty percent of outpatient prescription drug charges, after a two hundred fifty dollar calendar year deductible to a maximum of three thousand dollars in benefits received by the insured per calendar year, to the extent not covered by medicare. The outpatient prescription drug benefit may not be included for sale or issuance in a medicare supplement policy after December 31, 2005.

(h) Medically necessary emergency care in a foreign country: Coverage to the extent not covered by medicare for eighty percent of the billed charges for medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, that would have been covered by medicare if provided in the United States and that began during the first sixty consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars, and a lifetime maximum benefit of fifty thousand dollars. For purposes of this benefit, "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.

(i) Preventive medical care benefit: Coverage for the following preventive health services not covered by medicare:

(i) An annual clinical preventive medical history and physical examination that may include tests and services from (ii) of this subsection and patient education to address preventive health care measures.

(ii) Preventive screening tests or preventive services, the selection and frequency that is determined to be medically appropriate by the attending physician.

Reimbursement must be for the actual charges up to one hundred percent of the medicare-approved amount for each service, as if medicare were to cover the service as identified in *American Medical Association Current Procedural Terminology (AMA CPT)* codes, to a maximum of one hundred twenty dollars annually under this benefit. This benefit may not include payment for any procedure covered by medicare.

(j) At-home recovery benefit: Coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery.

(i) For purposes of this benefit, the following definitions apply:

(A) "Activities of daily living" include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

(B) "Care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide, or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

(C) "Home" means any place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by medicare. A hospital or skilled nursing facility is not considered the insured's place of residence.

(D) "At-home recovery visit" means the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive four hours in a twenty-four hour period of services provided by a care provider is one visit.

(ii) Coverage requirements and limitations.

(A) At-home recovery services provided must be primarily services that assist in activities of daily living.

(B) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by medicare.

(C) Coverage is limited to:

(I) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits may not exceed the number of medicare approved home health care visits under a medicare approved home care plan of treatment.

(II) The actual charges for each visit up to a maximum reimbursement of forty dollars per visit.

(III) One thousand six hundred dollars per calendar year.

(IV) Seven visits in any one week.

(V) Care furnished on a visiting basis in the insured's home.

(VI) Services provided by a care provider as defined in this section.

(VII) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded.

(VIII) At-home recovery visits received during the period the insured is receiving medicare approved home care services or no more than eight weeks after the service date of the last medicare approved home health care visit.

(iii) Coverage is excluded for: Home care visits paid for by medicare or other government programs; and care provided by family members, unpaid volunteers, or providers who are not care providers.

(5) Standardized medicare supplement benefit plan "K" must consist of the following:

(a) Coverage of one hundred percent of the Part A hospital coinsurance amount for each day used from the sixty-first through the ninetieth day in any medicare benefit period;

(b) Coverage of one hundred percent of the Part A hospital coinsurance amount for each medicare lifetime inpatient reserve day used from the ninety-first through the one hundred fiftieth day in any medicare benefit period;

(c) Upon exhaustion of the medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent of the medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five days. The provider must accept the issuer's payment as payment in full and may not bill the insured for any balance;

(d) Medicare Part A deductible: Coverage for fifty percent of the medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in (j) of this subsection;

(e) Skilled nursing facility care: Coverage for fifty percent of the coinsurance amount for each day used from the twenty-first day through the one hundredth day in a medicare benefit period for post-hospital skilled nursing facility care eligible under medicare Part A until the out-of-pocket limitation is met as described in (j) of this subsection;

(f) Hospice care: Coverage for fifty percent of cost sharing for all Part A medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in (j) of this subsection;

(g) Coverage for fifty percent, under medicare Part A or B, of the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulation) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in (j) of this subsection;

(h) Except for coverage provided in (i) of this subsection, coverage for fifty percent of the cost sharing otherwise applicable under medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in (j) of this subsection;

(i) Coverage of one hundred percent of the cost sharing for medicare Part B preventive services after the policyholder pays the Part B deductible; and

(j) Coverage of one hundred percent of all cost sharing under medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under medicare Parts A and B of four thousand dollars in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

(6) Standardized medicare supplement benefit plan "L" must consist of the following:

(a) The benefits described in subsection (4)(a), (b), (c) and (i) of this section;

(b) The benefit described in subsection (4)(d), (e), (f) and (h) of this section but substituting seventy-five percent for fifty percent; and

(c) The benefit described in subsection (4)(j) of this section but substituting two thousand dollars for four thousand dollars.

[Statutory Authority: RCW 48.66.030 (3)(a), 48.66.041, and 48.66.165. 09-24-052 (Matter No. R 2009-08), § 284-66-063, filed 11/24/09, effective 1/19/10. Statutory Authority: RCW 48.06.060 and 48.66.165. 07-06-014 (Matter No. R 2006-13), § 284-66-063, filed 2/26/07, effective 3/29/07. Statutory Authority: RCW 48.02.060 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-063, filed 8/4/05, effective 9/4/05. Statutory Authority: RCW 48.02.060, 48.66.041 and 48.66.165. 96-09-047 (Matter No. R 96-2), § 284-66-063, filed 4/11/96, effective 5/12/96. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.-050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-063, filed 2/25/92, effective 3/27/92.]

WAC 284-66-064 Benefit standards for policies or certificates issued or delivered on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a medicare supplement policy or certificate unless it complies with these benefit standards. Benefit standards applicable to medicare supplement policies or certificates issued before June 1, 2010, remain subject to the requirements of WAC 284-66-060 and 284-66-063.

(1) General standards. The following standards apply to medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

(a) A medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than three months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within three months before the effective date of coverage.

(b) A medicare supplement policy or certificate must provide that benefits designed to cover cost sharing amounts under medicare will be changed automatically to coincide with any changes in the applicable medicare deductible, copayment or coinsurance amounts. Premiums may be modified to correspond with such changes.

(c) No medicare supplement policy or certificate may 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.

(d) Each medicare supplement policy shall be guaranteed renewable and:

(i) The issuer may not cancel or nonrenew the policy solely on the ground of health status of the individual; and

(ii) The issuer may not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(iii) If the medicare supplement policy is terminated by the group policyholder and is not replaced as provided under (d)(v) of this subsection, the issuer shall offer certificate holders an individual medicare supplement policy which, at the option of the certificate holder:

(A) Provides for continuation of the benefits contained in the group policy; or

(B) Provides for benefits that otherwise meet the requirements of this subsection.

(iv) If an individual is a certificate holder in a group medicare supplement policy and the individual terminates membership in the group, the issuer must:

(A) Offer the certificate holder the conversion opportunity described in (d)(iii) of this subsection; or

(B) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(v) If a group medicare supplement policy is replaced by another group medicare supplement policy purchased by the same policyholder, the issue of the replacement policy must offer coverage to all persons covered under the old group policy on its date of termination.

(vi) Termination of a medicare supplement policy or certificate must 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 conditioned 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. Receipt of medicare Part D benefits will not be considered in determining a continuous loss.

(vii)(A) A medicare supplement policy or certificate must provide that benefits and premiums under the policy or certificate are suspended at the request of the policyholder or certificate holder for the period not to exceed twenty-four months in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within ninety days after the date the individual becomes entitled to assistance.

(B) If suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted, effective as of the date of termination of entitlement within ninety days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

(C) Each medicare supplement policy must provide that benefits and premiums under the policy must be suspended for any period that may be provided by federal regulation at the request of the policyholder if the policyholder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act. If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy must be automatically reinstituted effective as of the date of loss of coverage if the policyholder provides notice of loss of coverage within ninety days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.

(viii) Reinstitution of coverages as described in this section:

(A) Must not provide for any waiting period with respect to treatment of preexisting conditions;

(B) Must provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension; and

(C) Must provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

(2) Every issuer of medicare supplement insurance benefit plans A, B, C, D, F, F with high deductible, G, M, and N must make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other medicare supplement insurance plans in addition to the basic core package, but not in lieu of it.

(a) Coverage of Part A medicare eligible expenses for hospitalization to the extent not covered by medicare from the 61st day through the 90th day in any medicare benefit period.

(b) Coverage of Part A medicare eligible expenses incurred for hospitalization to the extent not covered by medicare for each medicare lifetime inpatient reserve day used;

(c) Upon exhaustion of the medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent of the medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system rate or other appropriate medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five days. The provider must accept the issuer's payment as payment in full and may not bill the insured for any balance;

(d) Coverage under medicare Parts A and B for the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations;

(e) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of medicare eligible expenses under Part B regardless of hospital confinement, subject to the medicare Part B deductible.

(f) Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

(3) The following additional benefits must be included in medicare supplement benefit Plans B, C, D, F, F with high deductible, G, M, and N as provided by WAC 284-66-066:

(a) Coverage for one hundred percent of the medicare Part A inpatient hospital deductible amount per benefit period.

(b) Coverage for fifty percent of the medicare Part A inpatient hospital deductible amount per benefit period.

(c) Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a medicare benefit period for posthospital skilled nursing facility care eligible under medicare Part A.

(d) Coverage for one hundred percent of the medicare part B deductible amount per calendar year regardless of hospital confinement.

(e) Coverage for all of the difference between the actual medicare Part B charges as billed, not to exceed any charge limitation established by the medicare program or state law, and the medicare-approved Part B charge.

(f) Coverage to the extent not covered by medicare for eighty percent of the billed charges for medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by medicare if provided in the United States and which care began during the first sixty consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars and a lifetime maximum benefit of fifty thousand dollars. For purposes of this benefit, "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.

[Statutory Authority: RCW 48.66.030 (3)(a), 48.66.041, and 48.66.165. 09-24-052 (Matter No. R 2009-08), § 284-66-064, filed 11/24/09, effective 1/19/10.]

WAC 284-66-066 Standard medicare supplement benefit plans. Standard medicare supplement benefit plans issued for delivery prior to June 1, 2010, must comply with this section.

(1) An issuer must make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic "core" benefits, as defined in WAC 284-66-063(2) of this regulation.

(2) No groups, packages, or combinations of medicare supplement benefits other than those listed in this section may be offered for sale in this state, except as permitted in WAC 284-66-066(7) and in WAC 284-66-073.

(3) Benefit plans must be uniform in structure, language, designation, and format to the standard benefit plans "A" through "L" listed in this subsection and conform to the definitions in WAC 284-66-030 and 284-66-040. Each benefit must be structured according to the format provided in WAC 284-66-063 (2), (3), (4) or (5) and list the benefits in the order shown in this subsection. For purposes of this section, "structure, language, and format" means style, arrangement, and overall content of benefit.

(4) An issuer may use, in addition to the benefit plan designations required in subsection (3) of this section, other designations to the extent permitted by law.

(5) Make-up of benefit plans:

(a) Standardized medicare supplement benefit plan "A" must be limited to only the basic ("core") benefits common to all benefit plans, as defined in WAC 284-66-063(2).

(b) Standardized medicare supplement benefit plan "B" consists of only the following: The core benefit as defined in WAC 284-66-063(2), plus the medicare Part A deductible as defined in WAC 284-66-063 (3)(a).

(c) Standardized medicare supplement benefit plan "C" consists of only the following: The core benefit as defined in WAC 284-66-063(2), plus the medicare Part A deductible, skilled nursing facility care, medicare Part B deductible and medically necessary emergency care in a foreign country as defined in WAC 284-66-063 (3)(a), (b), (c), and (h), respectively.

(d) Standardized medicare supplement plan "D" consists of only the following: The core benefit, as defined in WAC 284-66-063(2), plus the medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and the at-home recovery benefit as defined in WAC 284-66-063 (3)(a), (b), (h), and (j), respectively.

(e) Standardized medicare supplement benefit plan "E" consists of only the following: The core benefit as defined in WAC 284-66-063(2), plus the medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and preventive medical care as defined in WAC 284-66-063 (3)(a), (b), (h), and (i), respectively.

(f) Standardized medicare supplement benefit plan "F" consists of only the following: The core benefit as defined in WAC 284-66-063(2), plus the medicare Part A deductible, the skilled nursing facility care, the Part B deductible, one hundred percent of the medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in WAC 284-66-063 (3)(a), (b), (c), (e), and (h), respectively.

(g) Standardized medicare supplement benefit high deductible plan "F" consists of only the following: One hundred percent of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the core benefit as defined in WAC 284-66-063(2), plus the medicare Part A deductible, skilled nursing facility care, the medicare Part B deductible, one hundred percent of the medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in WAC 284-66-063 (3)(a), (b), (c), (e) and (h) respectively. The annual high deductible plan "F" deductible must consist of out-of-pocket expenses, other than premiums, for services covered by the medicare supplement plan "F" policy, and must be in addition to any other specific benefit deductibles. The annual high deductible plan "F" deductible is one thousand seven hundred thirty dollars for 2005, and is based on the calendar year. The deductible will be adjusted annually by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars.

(h) Standardized medicare supplement benefit plan "G" consists of only the following: The core benefit as defined at WAC 284-66-063(2), plus the medicare Part A deductible, skilled nursing facility care, eighty percent of the medicare Part B excess charges, medically necessary emergency care

in a foreign country, and the at-home recovery benefit as defined in WAC 284-66-063 (3)(a), (b), (d), (h), and (j), respectively.

(i) Standardized medicare supplement benefit plan "H" consists of only the following: The core benefit as defined in WAC 284-66-063(2), plus the medicare Part A deductible, skilled nursing facility care, basic prescription drug benefit, and medically necessary emergency care in a foreign country as defined in WAC 284-66-063 (3)(a), (b), (f), and (h), respectively. The outpatient prescription drug benefit may not be included in a medicare supplement policy sold after December 31, 2005.

(j) Standardized medicare supplement benefit plan "I" consists of only the following: The core benefit as defined in WAC 284-66-063(2), plus the medicare Part A deductible, skilled nursing facility care, one hundred percent of the medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country, and at-home recovery benefit as defined in WAC 284-66-063 (3)(a), (b), (e), (f), (h), and (j), respectively. The outpatient prescription drug benefit may not be included in a medicare supplement policy sold after December 31, 2005.

(k) Standardized medicare supplement benefit plan "J" consists of only the following: The core benefit as defined in WAC 284-66-063(2), plus the medicare Part A deductible, skilled nursing facility care, medicare Part B deductible, one hundred percent of the medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care, and at-home recovery benefit as defined in WAC 284-66-063 (3)(a), (b), (c), (e), (g), (h), (i), and (j), respectively. The outpatient prescription drug benefit may not be included in a medicare supplement policy sold after December 31, 2005.

(l) Standardized medicare supplement benefit high deductible plan "J" consists of only the following: One hundred percent of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the core benefit as defined in WAC 284-66-063(2), plus the medicare Part A deductible, skilled nursing facility care, medicare Part B deductible, one hundred percent of the medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventative medical care benefit and at-home recovery benefit as defined in WAC 284-66-063 (3)(a), (b), (c), (e), (g), (h), (i) and (j) respectively. The annual high deductible plan "J" deductible must consist of out-of-pocket expenses, other than premiums, for services covered by the medicare supplement plan "J" policy, and must be in addition to any other specific benefit deductibles. The annual deductible is one thousand seven hundred thirty dollars for 2005, and is based on the calendar year. The deductible will be adjusted annually by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars. The outpatient prescription drug benefit may not be included in a medicare supplement policy sold after December 31, 2005.

(6) Make-up of two medicare supplement plans mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA):

(a) Standardized medicare supplement benefit plan "K" consists of only those benefits described in WAC 284-66-063(4).

(b) Standardized medicare supplement benefit plan "L" consists of only those benefits described in WAC 284-66-063(5).

(7) New or innovative benefits: An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of medicare supplement policies. After December 31, 2005, the innovative benefits may not include an outpatient prescription drug benefit.

[Statutory Authority: RCW 48.66.030 (3)(a), 48.66.041, and 48.66.165. 09-24-052 (Matter No. R 2009-08), § 284-66-066, filed 11/24/09, effective 1/19/10. Statutory Authority: RCW 48.06.060 and 48.66.165. 07-06-014 (Matter No. R 2006-13), § 284-66-066, filed 2/26/07, effective 3/29/07. Statutory Authority: RCW 48.02.060 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-066, filed 8/4/05, effective 9/4/05. Statutory Authority: RCW 48.02.060. 92-17-078 (Order R 92-7), § 284-66-066, filed 8/19/92, effective 9/19/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.-030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-066, filed 2/25/92, effective 3/27/92.]

WAC 284-66-067 Standard medicare supplement plans issued for delivery on or after June 1, 2010. No policy or certificate delivered or issued for delivery in this state on or after June 1, 2010, as a medicare supplement policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to medicare supplement policies and certificates issued before June 1, 2010, remain subject to the requirements of WAC 284-66-066.

(1)(a) An issuer must make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic or core benefits, as defined in WAC 284-66-064.

(b) If an issuer makes available any of the additional benefits described in WAC 284-66-064 or offers standardized benefit Plan K or L as described in subsection (5) of this section, then the issuer shall make available to each prospective policyholder and certificate holder, in addition to a policy form or certificate form with only the basic or core benefits as described in (a) of this section, a policy form or certificate form containing either standardized benefit Plan C or standardized benefit Plan F.

(2) No groups, packages or combinations of medicare supplement benefits other than those listed in this section may be offered for sale in this state, except as may be permitted in WAC 284-66-064 and 284-66-073.

(3) Benefit plans must be uniform in structure, language, designation and format to the standard benefit plans listed in this section and conform to the definitions in this chapter.

Each benefit must be structured in accordance with the format found in WAC 284-66-064 or in the case of Plans K or L, in subsection (5) of this section, and list the benefits in the order shown. For purposes of this section, "structure, language and format" means style, arrangement and overall content of a benefit.

(4) In addition to the benefit plan designations required in subsection (3) of this section, an issuer may use other designations to the extent permitted by law.

(5) Make-up of 2010 Standardized Benefit Plans:

(a) Standardized medicare supplement benefit Plan A may include only the basic core benefits as defined in WAC 284-66-064.

(b) Standardized medicare supplement benefit Plan B may include only the basic core benefit as defined in WAC 284-66-064 plus one hundred percent of the medicare part A deductible as defined in WAC 284-66-064.

(c) Standardized medicare supplement benefit Plan C may include only the basic core benefit as defined in WAC 284-66-064 plus one hundred percent of the medicare Part A deductible, skilled nursing facility care, one hundred percent of the medicare Part B deductible and medically necessary emergency care in a foreign country as defined in WAC 284-66-064.

(d) Standardized medicare supplement benefit Plan D may include only the basic core benefits as defined in WAC 284-66-064 plus one hundred percent of the medicare Part A deductible, skilled nursing facility care and medically necessary emergency care in a foreign country as defined in WAC 284-66-064.

(e) Standardized medicare supplement regular Plan F may include only the basic core benefit as defined in WAC 284-66-064 plus one hundred percent of the medicare Part A deductible, the skilled nursing facility care, one hundred percent of the medicare Part B deductible, one hundred percent of the medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in WAC 284-66-064.

(f) Standardized medicare supplement Plan F with high deductible may include only one hundred percent of covered expenses following the payment of the annual deductible set forth in (f)(ii) of this subsection.

(i) The basic core benefit as defined in WAC 284-66-064 plus one hundred percent of the medicare Part A deductible, skilled nursing facility care, one hundred percent of the medicare Part B deductible, one hundred percent of the medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in WAC 284-66-064.

(ii) The annual deductible in Plan F with high deductible must consist only of out-of-pocket expenses, other than premiums, for services covered by regular Plan F and must be in addition to any other specific benefit deductibles. The basis for the deductible must be one thousand five hundred dollars and will be adjusted annually from 1999 by the Secretary of the U.S. Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars.

(g) Standardized medicare supplement benefit Plan G may include only the basic core benefit as defined in WAC 284-66-064, plus one hundred percent of the medicare Part A deductible, skilled nursing facility care, one hundred percent of the medicare part B excess charges and medically necessary emergency care in a foreign country as defined in WAC 284-66-064.

(h) Standardized medicare supplement benefit Plan K is mandated by the Medicare Prescription Drug Improvement and Modernization Act of 2003, and may include only the following:

(i) Coverage of one hundred percent of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any medicare benefit period;

(ii) Coverage of one hundred percent of the Part A hospital coinsurance amount for each medicare lifetime inpatient reserve day used from the 91st through the 150th day in any medicare benefit period;

(iii) Upon exhaustion of the medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent of the medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system rate or other appropriate medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five days. The provider must accept the insurer's payment as payment in full and may not bill the insured for any balance;

(iv) Coverage for fifty percent of the medicare part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in (h)(x) of this subsection;

(v) Skilled nursing facility care coverage for fifty percent of the coinsurance amount for each day used from the 21st day through the 100th day in a medicare benefit period for posthospital skilled nursing facility care eligible under medicare Part A until the out-of-pocket limitation is met as described in (h)(x) of this subsection;

(vi) Coverage for fifty percent of cost sharing for all Part A medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in (h)(x) of this subsection;

(vii) Coverage for fifty percent under medicare Part A or B of the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells as defined under federal regulations unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in (h)(x) of this subsection;

(viii) Except for coverage provided in (h)(ix) of this subsection, coverage for fifty percent of the cost sharing otherwise applicable under medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in (h)(x) of this subsection;

(ix) Coverage of one hundred percent of the cost sharing for medicare part B preventive services after the policyholder pays the part B deductible; and

(x) Coverage of one hundred percent of all cost sharing under medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under medicare Parts A and B of four thousand dollars in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

(i) Standardized medicare supplement Plan L as mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 may include only the following:

(i) The benefits described in (h)(i) through (vi) and (ix) of this subsection; and

(ii) The benefit described in (h)(i) through (vi) and (vii) of this subsection but substituting seventy-five percent for fifty percent; and

(iii) The benefit described in (h)(x) of this subsection but substituting two thousand dollars for four thousand dollars.

(j) Standardized medicare supplement Plan M may include only the basic core benefit as defined in WAC 284-66-064, plus fifty percent of the medicare Part A deductible, skilled nursing facility care and medically necessary emergency care in a foreign country as defined in WAC 284-66-064.

(k) Standardized medicare supplement Plan N may include only the basic core benefit as defined in WAC 284-66-064, plus one hundred percent of the medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in subsection (3) of this section, with copayments in the following amounts:

(i) The lesser of twenty dollars or the medicare coinsurance or copayment for each covered health care provider office visit, including visits to medical specialists Part B; and

(ii) The lesser of fifty dollars or the medicare Part B coinsurance of copayment for each covered emergency room visit, however this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a medicare Part A expense.

(6) An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include only benefits that are appropriate to medicare supplement insurance, are new or innovative, are not otherwise available, and are cost-effective. Approval of new or innovative benefits must not adversely impact the goal of medicare supplement simplification. New or innovative benefits may not include an outpatient prescription drug benefit. New or innovative benefits may not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

[Statutory Authority: RCW 48.66.030 (3)(a), 48.66.041, and 48.66.165. 09-24-052 (Matter No. R 2009-08), § 284-66-067, filed 11/24/09, effective 1/19/10.]

WAC 284-66-068 Prohibition against use of genetic information and requests for genetic testing. Effective May 21, 2009, except as provided in subsection (3) of this section:

(1) An issuer of a medicare supplement insurance policy or certificate must not deny or condition the issuance of effectiveness of the policy or certificate and must not discriminate in the pricing of the policy or certificate of an individual on the basis of the genetic information with respect to any individual. This includes the imposition of any exclusion of benefits under the policy based on a preexisting condition or adjustment of premium rates based on genetic information. This subsection shall not be construed to limit the ability of an issuer, to the extent otherwise permitted by law from:

(a) Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium based on the manifestation of a disease or disorder of the insured or applicant; or

(b) Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy. The manifestation of a disease or disorder in one individual must not be used as genetic information about other group members or to increase the premium for the group.

(2) An issuer of a medicare supplement insurance policy or certificate must not request or require an individual or a family member of the individual to undergo a genetic test. This subsection shall not be construed to preclude an issuer from obtaining and using the results of a genetic test in making a determination regarding payment consistent with subsection (1) of this section. For purposes of this section, "payment" has the meaning set forth in Part C of Title XI and Section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time. An issuer may request only the minimum information necessary to accomplish the intended purpose.

(3) An issuer may request, but must not require, that an individual or a family member of the individual undergo a genetic test only if all of the following conditions are met:

(a) The request is made for research that complies with Part 46 of Title 45, Code of Federal Regulations, or its equivalent, or any other applicable state or local law or rule for the protection of human subjects in research;

(b) The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of the child, to whom the request is made that:

(i) Compliance with the request is voluntary; and

(ii) Noncompliance will have no effect on enrollment status or premium or contribution amounts;

(c) Genetic information collected or acquired under this subsection must not be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate;

(d) The issuer notifies the secretary of the United States Department of Health and Human Services in writing that the issuer is conducting activities pursuant to the exception provided for under this subsection, including a description of the activities conducted;

(e) The issuer complies with all other conditions required by regulation by the secretary of the United States Department of Health and Human Services for activities conducted under this subsection;

(4) An issuer must not request, require, or purchase genetic information for underwriting purposes;

(5) An issuer shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment; and

(6) If an issuer obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, the request, requirement, or purchase will not be considered a violation of subsection (5) of

this section only if the request, requirement, or purchase is not in violation of subsection (4) of this section.

(7) For purposes of this section:

(a) "Issuer" has the meaning set forth in WAC 284-66-030(4) and includes any third-party administrator or other person acting for or on behalf of the issuer.

(b) "Family member" means any individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of the individual.

(c) "Genetic information" means information about the individual's genetic tests, the genetic tests of family members of the individual, and the manifestation of a disease or disorder in family members. The term includes any requests for or receipt of genetic services or participation in clinical research which includes genetic services by the individual or a family member. Any reference to genetic information concerning an individual or family member who is a pregnant woman includes genetic information of any fetus carried by the pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. Genetic information does not include information about the gender or age of any individual.

(d) "Genetic services" means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education.

(e) "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations, or chromosomal changes. The term genetic test does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(f) "Underwriting purposes" means:

(i) Rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the policy;

(ii) The computation of premium or contribution amounts under the policy;

(iii) The application of any preexisting condition exclusion under the policy; and

(iv) Other activities related to the creation, renewal, or replacement of a policy of health insurance or health benefits.

[Statutory Authority: RCW 48.66.165. 09-05-004 (Matter No. R 2008-23), § 284-66-068, filed 2/4/09, effective 3/7/09.]

WAC 284-66-080 Outline of coverage required. (1) Issuers must provide an outline of coverage to all applicants at the time an application is presented to the prospective applicant and, except for direct response policies and certificates, must obtain an acknowledgment of receipt of the outline from the applicant.

(2) The "outline of coverage," is set forth on the commissioner's web site, and incorporated by reference herein in this rule. The issuer's form of outline of coverage must be completed in substantially the form set forth on the commissioner's web site, and filed with the commissioner before being used in this state.

(3) If an outline of coverage is provided at the time of application and the medicare supplement policy or certificate is issued on a basis that would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must accompany the policy or certificate 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."

(4) The outline of coverage provided to applicants set forth in this section consists of four parts: A cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage must be in the language and format prescribed in WAC 284-66-092 in no less than twelve point type. All plans A- N must be shown on the cover page, and the plan(s) that are offered by the issuer must be prominently identified. Premium information for plans that are offered must be shown on the cover page or immediately following the cover page and must be prominently displayed. The premium and mode must be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant must be illustrated.

(5) Where inappropriate terms are used, such as "insurance," "policy," or "insurance company," a fraternal benefit society, health care service contractor, or health maintenance organization must substitute appropriate terminology.

[Statutory Authority: RCW 48.66.030 (3)(a), 48.66.041, and 48.66.165. 09-24-052 (Matter No. R 2009-08), § 284-66-080, filed 11/24/09, effective 1/19/10. Statutory Authority: RCW 48.02.060 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-080, filed 8/4/05, effective 9/4/05. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.-010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-080, filed 2/25/92, effective 3/27/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130, 48.46.-200, 48.66.041, 48.66.050, 48.66.100, 48.66.110, 48.66.120, 48.66.130, 48.66.150 and 48.66.160. 90-07-059 (Order R 90-4), § 284-66-080, filed 3/20/90, effective 4/20/90.]

WAC 284-66-232 Form for medicare supplement refund calculation.

MEDICARE SUPPLEMENT REFUND CALCULATION FORM FOR CALENDAR YEAR _____

TYPE _____ SMSBP(w)_____
For the State of _____
Washington Policy or Certificate Form No(s). _____
Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Person Completing This Exhibit _____
Title _____ Telephone Number _____

Line	(a) Earned Premium (x)	(b) Incurred Claims (y)
1. Current Year's Experience a. Total (all policy years) b. Current year's issues (z) c. Net (for reporting purposes = 1a - 1b)		
2. Past Years' Experience (All Policy Years)		
3. Total experience (Net Current Year + Past Years' Experience)		
4. Refunds Last year (Excluding Interest)		
5. Previous Since Inception (Excluding Interest)		
6. Refunds Since Inception (Excluding Interest)		
7. Benchmark Ratio Since Inception (SEE WORKSHEET FOR RATIO 1)		
8. Experienced Ratio Since Inception **Total Actual Incurred Claims (line 3, col b) = Ratio 2** **Total Earned Premium (line 3, col a) - Refunds Since Inception (line 6)**		
9. Life Years Exposed Since Inception If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.		
10. Tolerance Permitted (obtained from credibility table)		
11. Adjustment to incurred Claims for Credibility **Ratio 3 = Ratio 2 + Tolerance** If Ratio 3 is more than benchmark ratio (ratio 1), a refund or credit to premium is not required. If Ratio 3 is less than the benchmark ratio, then proceed.		
12. Adjust Incurred Claims = **[Total Earned Premium (line 3, col. a) - Refunds Since Inception (line 6)]** **X Ratio 3 (line 11)**		
13. Refund =**Total Earned Premiums (line 3, col a) -** **Refunds Since Inception (line 6) -** **Adjusted Incurred Claims (line 12)** **Benchmark Ratio (Ratio 1)** If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund and/or credit against premiums to be used must be attached to this form.		

Medicare Supplement Credibility Table

Life Year Exposed Since Inception	Tolerance
10,000+	0.0%
5,000 - 9,999	5.0%
2,500 - 4,999	7.5%
1,000 - 2,499	10.0%
500 - 999	15.0%
If Less than 500	No credibility

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR_____

TYPE _____ SMSBP(w)_____
For the State of _____
Washington Policy or Certificate Form No(s). _____
Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Person Completing This Exhibit _____
Title _____ Telephone Number _____

(w) "SMSBP" = Standardized Medicare Supplement Benefit Plan
(x) Includes modal loadings and fees charged.
(y) Excludes Active Life Reserves.
(z) This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios"

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____
Signature

_____
Name - Please Type

_____
Title

_____
Date

WORKSHEET #1 - INDIVIDUAL POLICIES

REPORTING FORM FOR TIME CALCULATION OF
BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL POLICIES
FOR CALENDAR YEAR _____

TYPE _____ SMSBP (P) _____
FOR THE STATE OF WASHINGTON_____
Washington Policy or Certificate Form No. _____
Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____
Person Completing This Exhibit _____
Title _____ Telephone Number _____

(a) Year	(b) Earned Premium	(c) Factor	(d) (b) x (c)	(e) Cumulative Loss Ratio	(f) (d) x (e)	(g) Factor	(h) (b) x (g)	(i) Cumulative Loss Ratio	(j) (h) x (i)	(o) Policy Year Loss Ratio
1		2.770		0.442		0.000		0.000		0.40
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15+[1]		4.175		0.493		8.684		0.725		0.77
Total:			(k):		(1):		(m):		(n):	

FN for 15+[1]: To include the earned premium for all years prior to as well as the 15th year prior to the current year.

Benchmark Ratio Since Inception: (1 + n) / (k + m):

(a): Year 1 is the current calendar year - 1
Year 2 is the current calendar year - 2 (etc.)
(Example: If the current year is 1991, then:
Year 1 is 1990: Year 2 is 1989; etc.)

(b): For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

k = Total of Column "d"
l = Total of Column "f"
m = Total of Column "h"
n = Total of Column "j"

(p) "SMSBP" = Standardized Medicare Supplement Benefit Plan

(o): These loss ratios are not explicitly used in computing the benchmark loss ratios.
They are the loss ratios, on a policy year basis, which result in the cumulative loss ratio displayed on this worksheet. They are shown here for informational purposes only.

WORKSHEET #1 - GROUP POLICIES

REPORTING FORM FOR TIME CALCULATION OF
BENCHMARK RATIO SINCE INCEPTION
FOR GROUP POLICIES
FOR CALENDAR YEAR _____

TYPE _____ SMSBP (P) _____
FOR THE STATE OF WASHINGTON_____
Washington Policy or Certificate Form No. _____
Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____
Person Completing This Exhibit _____
Title _____ Telephone Number _____

(a) Year	(b) Earned Premium	(c) Factor	(d) (b) x (c)	(e) Cumulative Loss Ratio	(f) (d) x (e)	(g) Factor	(h) (b) x (g)	(i) Cumulative Loss Ratio	(j) (h) x (i)	(o) Policy Year Loss Ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.8
6		4.175		0.567		3.998		0.792		0.82

(a) Year	(b) Earned Premium	(c) Factor	(d) (b) x (c)	(e) Cumulative Loss Ratio	(f) (d) x (e)	(g) Factor	(h) (b) x (g)	(i) Cumulative Loss Ratio	(j) (h) x (i)	(o) Policy Year Loss Ratio
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15+		4.175		0.567		8.684		0.838		0.89
Total:			(k):		(l):		(m):		(n):	

FN for 15+: To include the earned premium for all years prior to as well as the 15th year prior to the current year.

Benchmark Ratio Since Inception: (1 + n) / (k + m):

(b): For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

k = Total of Column "d"
l = Total of Column "f"
m = Total of Column "h"
n = Total of Column "j"

(a): Year 1 is the current calendar year - 1
Year 2 is the current calendar year - 2 (etc.)
(Example: If the current year is 1991, then:
Year 1 is 1990: Year 2 is 1989; etc.)

(p) "SMSBP" = Standardized Medicare Supplement Benefit Plan

(o): These loss ratios are not explicitly used in computing the benchmark loss ratios.
They are the loss ratios, on a policy year basis, which result in the cumulative loss ratio displayed on this worksheet. They are shown here for informational purposes only.

[Statutory Authority: RCW 48.66.030 (3)(a), 48.66.041, and 48.66.165. 09-24-052 (Matter No. R 2009-08), § 284-66-232, filed 11/24/09, effective 1/19/10. Statutory Authority: RCW 48.02.060. 93-01-048 (Order 92-25), § 284-66-232, filed 12/10/92, effective 1/10/93. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-232, filed 2/25/92, effective 3/27/92.]

WAC 284-66-243 Filing and approval of policies and certificates and premium rates. (1) An issuer may not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the commissioner according to the filing requirements and procedures prescribed by the commissioner.

(2) An issuer may not use or change premium rates for a medicare supplement policy or certificate unless the rates, rating schedule, and supporting documentation have been filed with and approved by the commissioner according to the filing requirements and procedures prescribed by the commissioner.

(3)(a) Except as provided in (b) of this subsection, an issuer may not file for approval more than one form of a policy or certificate of each type for each standard medicare supplement benefit plan.

(b) An issuer may offer, with the approval of the commissioner, up to four additional policy forms or certificate forms of the same type for the same standard medicare supplement benefit plan, one for each of the following cases:

(i) The inclusion of new or innovative benefits;

(ii) The addition of either direct response or agent marketing methods;

(iii) The addition of either guaranteed issue or underwritten coverage;

(iv) The offering of coverage to individuals eligible for medicare by reason of disability. The form number for products offered to enrollees who are eligible by reason of disability must be distinct from the form number used for a corresponding standardized plan offered to an enrollee eligible for medicare by reason of age.

(c) For the purposes of this section, a "type" means an individual policy, a group policy, an individual medicare SELECT policy, or a group medicare SELECT policy.

(4)(a) Except as provided in (a)(i) of this subsection, an issuer must continue to make available for purchase any policy form or certificate form issued after the effective date of this regulation that has been approved by the commissioner. A policy form or certificate form is not considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve months.

(i) An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the commissioner in writing its decision at least thirty days before discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the commissioner, the issuer may no longer offer for sale the policy form or certificate form in this state.

(ii) An issuer that discontinues the availability of a policy form or certificate form under (a)(i) of this subsection, may not file for approval a new policy form or certificate form of the same type for the same standard medicare supplement benefit plan as the discontinued form for a period of five years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.

(b) The sale or other transfer of medicare supplement business to another issuer is considered a discontinuance for the purposes of this subsection.

(c) A change in the rating structure or methodology is considered a discontinuance under (a) of this subsection, unless the issuer complies with the following requirements:

(i) The issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in that the revised rating methodology and resultant rates differ from the existing rating methodology and resultant rates.

(ii) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential that is in the public interest.

(5)(a) Except as provided in (b) of this subsection, the experience of all policy forms or certificate forms of the same type in a standard medicare supplement benefit plan must be combined for purposes of the refund or credit calculation prescribed in WAC 284-66-203.

(b) Forms assumed under an assumption reinsurance agreement may not be combined with the experience of other forms for purposes of the refund or credit calculation.

(6) An issuer may set rates only on a community rated basis or on an issue-age level premium basis for policies issued prior to January 1, 1996, and may set rates only on a community rated basis for policies issued after December 31, 1995.

(a) For policies issued prior to January 1, 1996, community rated premiums must be equal for all individual policyholders or certificateholders under a standardized medicare supplement benefit form. Such premiums may not vary by age or sex. For policies issued after December 31, 1995, community rated premiums must be set according to RCW 48.66.045(3).

(b) Issue-age level premiums must be calculated for the lifetime of the insured. This will result in a level premium if the effects of inflation are ignored.

(7) All filings of policy or certificate forms must be accompanied by the proposed application form, outline of coverage form, proposed rate schedule, and an actuarial memorandum completed, signed and dated by a qualified actuary as defined in WAC 284-05-060. In addition to the actuarial memorandum, the following supporting documentation must be submitted to demonstrate to the satisfaction of the commissioner that rates are not excessive, inadequate, or unfairly discriminatory and otherwise comply with the requirements of this chapter:

(a) Anticipated loss ratios stated on a calendar year basis by duration for the period for which the policy is rated. Filings of future rate adjustments must contain the actual calendar year loss ratios experienced since inception, both before and after the refund required, if any and the actual loss ratios in comparison to the expected loss ratios stated in the initial rate filing on a calendar year basis by duration if applicable;

(b) Anticipated total termination rates on a calendar year basis by duration for the period for which the policy is rated. The termination rates should be stated as a percentage and the source of the mortality assumption must be specified. Filings of future rate adjustments must include the actual total termination rates stated on a calendar year basis since inception;

(c) Expense assumptions including fixed and percentage expenses for acquisition and maintenance costs;

(d) Schedule of total compensation payable to agents and other producers as a percentage of premium, if any;

(e) A complete specimen copy of the compensation agreements or contracts between the issuer and its agents, brokers, general agents, as well as the contracts between general agents and agents or others whose compensation is based in whole or in part on the sale of medicare supplement insurance policies. The agreements must demonstrate compliance with WAC 284-66-350 (where appropriate);

(f) Other data necessary in the reasonable opinion of the commissioner to substantiate the filing.

[Statutory Authority: RCW 48.66.030 (3)(a), 48.66.041, and 48.66.165. 09-24-052 (Matter No. R 2009-08), § 284-66-243, filed 11/24/09, effective 1/19/10. Statutory Authority: RCW 48.02.060 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-243, filed 8/4/05, effective 9/4/05. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.-010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-243, filed 2/25/92, effective 3/27/92.]

WAC 284-66-323 Form for reporting multiple medicare supplement policies and certificates.

Medicare Supplement Regulation

FORM FOR REPORTING
MEDICARE SUPPLEMENT POLICIES

Company Name: _____
Address: _____
_____
Phone Number: _____

Due: March 1, annually

The purpose of this form is to report the following information on each resident of this state with more than one medicare supplement policy or certificate in force. The information is to be grouped by individual policyholder.

Policy and Certificate #	Date of Issuance

_____
Signature

_____
Name and Title (please type)

Date

[Statutory Authority: RCW 48.66.030 (3)(a), 48.66.041, and 48.66.165. 09-24-052 (Matter No. R 2009-08), § 284-66-323, filed 11/24/09, effective 1/19/10. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-323, filed 2/25/92, effective 3/27/92.]

Chapter 284-96 WAC
GROUP AND BLANKET DISABILITY INSURANCE

WAC

WAC 284-96-012 Discretionary clauses prohibited. (1) No disability insurance policy may contain a discretionary clause. "Discretionary clause" means a provision that purports to reserve discretion to an insurer, its agents, officers, employees, or designees in interpreting the terms of a policy or deciding eligibility for benefits, or requires deference to such interpretations or decisions, including a provision that provides for any of the following results:

(a) That the insurer's interpretation of the terms of the policy is binding;

(b) That the insurer's decision regarding eligibility or continued receipt of benefits is binding;

(c) That the insurer's decision to deny, modify, reduce or terminate payment, coverage, authorization, or provision of health care service or benefits, is binding;

(d) That there is no appeal or judicial remedy from a denial of a claim;

(e) That deference must be given to the insurer's interpretation of the contract or claim decision; and

(f) That the standard of review of an insurer's interpretation of the policy or claim decision is other than a de novo review.

(2) Nothing in this section prohibits an insurer from including a provision in a policy that informs an insured that as part of its routine operations the insurer applies the terms of its policies for making decisions, including making determination regarding eligibility, receipt of benefits and claims, or explaining its policies, procedures, and processes.

[Statutory Authority: RCW 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.200, 48.02.060, 48.18.110, 48.44.020, and 48.46.060. 09-16-128 (Matter No. R 2008-25), § 284-96-012, filed 8/5/09, effective 9/5/09.]

Chapter 284-155 WAC
HEALTH CARE DISCOUNT PLAN ORGANIZATION STANDARDS

WAC

WAC 284-155-005 Purpose. These regulations implement chapter 48.155 RCW and create the processes and procedures for licensing a discount plan organization.

[Statutory Authority: RCW 48.155.007 and 48.02.060. 09-22-064 (Matter No. R 2009-10), § 284-155-005, filed 11/2/09, effective 12/3/09.]

WAC 284-155-010 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise:

"Applicant" means any discount plan organization applying for a license under these regulations, and includes a discount plan organization or person holding a license or other form of authority from another state to operate as a discount plan organization.

"Application" means the written request for a license and the information required by the commissioner to obtain a license to transact discount plan business.

"License" means the license issued by the commissioner required to transact discount plan business under these regulations.

"Renewal application" means the renewal application under these regulations.

[Statutory Authority: RCW 48.155.007 and 48.02.060. 09-22-064 (Matter No. R 2009-10), § 284-155-010, filed 11/2/09, effective 12/3/09.]

WAC 284-155-015 Licensing forms and filing procedures. (1) An applicant applying for a new license or a licensed discount plan organization applying for license renewal must complete and file all required forms. All forms, including the application form, the renewal form, and the annual report form required by this regulation are available on the commissioner's web site at www.insurance.wa.gov. Applicants must fully complete and file only forms approved by the commissioner.

(2) If a licensed discount plan organization fails to file the renewal application or the renewal application fee sooner than ninety days before its license expires, the license will expire on its expiration date and the discount plan organization must complete and file a new application and pay the fee for a new license.

(3) Upon the expiration of a discount plan organization's license, all operations must be immediately suspended, including any advertising, marketing, solicitation, enrollment, and renewal of contracts or other activities specified under these regulations.

(4) Annual report filing requirements:

(a) Licensed discount plan organizations are not required to prepare a separate annual report filing or pay the annual report fee if they file the information required for their annual report at the time they file their renewal application, but only if they do so prior to the March 31st deadline for filing the annual report.

(b) If a licensed discount plan organization does not include its annual report information with its renewal application, it must file an annual report with the commissioner prior to the March 31st deadline for filing an annual report. If the renewal application is due after March 31st, a licensed discount plan organization must file an annual report by March 31st, and may not defer filing the annual report on the

basis that it plans to include the annual report information with its renewal.

(5) Any discount plan organization that has transacted or is transacting discount plan business to which the regulation applies prior to or as of July 26, 2009, must complete and file the commissioner's required application form along with all other required forms and information, on or before January 26, 2010. If a discount plan organization does not apply for a license as specified by the commissioner on or before October 26, 2009, it must discontinue operations after January 26, 2010, unless the commissioner has issued the license by January 26, 2010.

[Statutory Authority: RCW 48.155.007 and 48.02.060. 09-22-064 (Matter No. R 2009-10), § 284-155-015, filed 11/2/09, effective 12/3/09.]

WAC 284-155-020 Audited financial statements. (1) All audited financial statements filed with the commissioner under these regulations must:

(a) Be prepared in accordance with generally accepted auditing principles;

(b) Be certified by an independent certified public accountant; and

(c) Meet the standards and requirements of WAC 284-07-100 through 284-07-230 to the extent reasonably applicable, provided, that WAC 284-07-100 (5), (6), and (7) shall not apply to discount plan organizations; and provided further, that discount plan organizations shall not be required to file any report, letter, or other document required to be filed with the commissioner by WAC 284-07-100 through 284-07-230 with the National Association of Insurance Commissioners (NAIC).

(2) All audited financial statements filed with an annual report under this regulation shall cover the same fiscal period as the discount plan organization's annual report.

(3) Unless an applicant has the commissioner's written permission, the applicant's own most recent financial statements audited by an independent certified public accountant must accompany the application. An applicant granted prior permission by the commissioner to substitute its parent company's audited financial statements for the financial statements of the applicant must specifically segregate and report the applicant's financial results as required by the commissioner.

(4) Unless a licensed discount plan organization has the commissioner's written permission, the licensee must include its own most recent financial statements audited by an independent certified public accountant with its renewal application or the annual report filed with the commissioner. A discount plan organization granted prior permission by the commissioner to substitute its parent company's audited financial statements for the financial statements of the applicant must specifically segregate and report the discount plan organization's financial results as required by the commissioner.

(5) If the commissioner determines there is good cause for a delay, the commissioner may grant an extension of time to file the audited financial statement. Discount plan organizations or applicants must submit a written request for an extension of time to file the audited financial statement at least ten business days prior to the filing deadline.

[Statutory Authority: RCW 48.155.007 and 48.02.060. 09-22-064 (Matter No. R 2009-10), § 284-155-020, filed 11/2/09, effective 12/3/09.]

WAC 284-155-025 Indemnity requirements for discount plan organizations. (1) A discount plan organization providing a surety bond to protect the financial interests of Washington members must name the state of Washington as the obligee, but the bond will be for the benefit of the Washington members who have purchased the discount plan.

(2) All surety bonds obtained by discount plan organizations for the purpose of complying with their financial responsibility under this section must operate to ensure Washington consumers provision of all terms of their discount plan membership, including refunds.

(3) A discount plan organization, in lieu of a surety bond, may provide a deposit in trust with the commissioner to protect the financial interests of Washington members as set forth in RCW 48.155.040.

(a) The deposit in trust must be in cash or other investments specifically authorized and eligible for investment pursuant to chapter 48.13 RCW.

(b) All deposits and withdrawals must be made by using forms found on the commissioner's web site at www.insurance.wa.gov.

[Statutory Authority: RCW 48.155.007 and 48.02.060. 09-22-064 (Matter No. R 2009-10), § 284-155-025, filed 11/2/09, effective 12/3/09.]

WAC 284-155-030 Discount plan organization—General requirements for records availability and form and report filing. (1) All discount plan organization records and reports must be maintained at the discount plan organization's principal business address and are subject to review by the commissioner's representatives during the discount plan organization's usual and customary business hours.

(2) The commissioner may require discount plan organizations to provide copies of discount plan organization documents, records, and reports in lieu of making the records available for on-site review.

(3) All records, reports, notices, or other documents required by this regulation must be transmitted electronically in Adobe Acrobat PDF format.

(4) A discount plan organization must respond promptly to any inquiry from the insurance commissioner relative to the business of a discount plan organization. A lack of response within fifteen business days from the receipt of an inquiry will be considered untimely. A response must be in writing, unless otherwise indicated in the inquiry.

[Statutory Authority: RCW 48.155.007 and 48.02.060. 09-22-064 (Matter No. R 2009-10), § 284-155-030, filed 11/2/09, effective 12/3/09.]