

Chapter 284-30 WAC TRADE PRACTICES

Last Update: 5/14/21

WAC

THE UNFAIR CLAIMS SETTLEMENT PRACTICES REGULATION

284-30-300	Authority and purpose.
284-30-310	Scope of this regulation.
284-30-320	Definitions.
284-30-330	Specific unfair claims settlement practices defined.
284-30-340	File and record documentation.
284-30-350	Misrepresentation of policy provisions.
284-30-355	Certificates of insurance.
284-30-360	Standards for the insurer to acknowledge pertinent communications.
284-30-370	Standards for prompt investigation of a claim.
284-30-380	Settlement standards applicable to all insurers.
284-30-390	Acts or practices considered unfair in the settlement of motor vehicle claims.
284-30-391	Methods and standards of practice for settlement of total loss vehicle claims.
284-30-392	Information that must be included in the insurer's total loss vehicle valuation report.
284-30-393	Insurer must include an insured's deductible in its subrogation demands.
284-30-394	Denial of storage and towing costs.
284-30-395	Standards for prompt, fair and equitable settlements applicable to automobile personal injury protection insurance.
284-30-400	Enforcement.
284-30-450	Insurance policies and contracts—Coverage for drugs.

TRADE PRACTICES

284-30-500	Unfair practices with respect to vehicle insurance.
284-30-550	Receipts to be given.
284-30-560	Applications and binders.
284-30-570	Actual reason for canceling, denying or refusing to renew insurance to be disclosed.
284-30-572	Discrimination prohibited.
284-30-574	Insurer must make independent evaluation.
284-30-580	Policies to be delivered, not held by insurance producers or title insurance agents.
284-30-590	Unfair practices with respect to policy cancellations, renewals, and changes.
284-30-595	Unfair practices regarding documented expenses for implementation credits.
284-30-600	Unfair practices with respect to out-of-state group life and disability insurance.
284-30-610	Unfair practices with respect to the solicitation of coverage under out-of-state group policies.
284-30-620	Permissible time limit for benefits payable because of accidental injury or death.
284-30-630	Health questions in applications to be clear and precise.
284-30-650	Prompt responses required.
284-30-660	Deceptive use of quotations or evaluations prohibited.
284-30-670	Insurers must transact business in their legal name.
284-30-700	Restrictions as to denial and termination of homeowners insurance affected by day-care operations.
284-30-750	Insurance producers' and surplus line brokers' fees to be disclosed.
284-30-770	Adverse notification requirements.

MILITARY SALES PRACTICES

284-30-850	Authority, purpose, and effective date.
284-30-855	Scope.
284-30-860	Exemptions.
284-30-865	Definitions.
284-30-870	Practices declared to be unfair or deceptive when committed on a military installation.
284-30-872	Practices declared to be unfair or deceptive regardless of where they occur.

ENVIRONMENTAL CLAIMS

284-30-900	Purpose.
284-30-905	Scope.
284-30-910	Definitions.
284-30-920	Procedures for resolving lost policy disputes regarding environmental claims.
284-30-930	Specific unfair environmental claims settlement or trade practices defined.
284-30-940	Environmental claim mediation program.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-30-005	Which regulation applicable. [Order R-71-1, § 284-30-005, filed 6/15/71, effective 9/1/71.] Repealed by WSR 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
284-30-010	Replacement of life insurance policies. [Order R-68-10, § 284-30-010, filed 10/25/68; Order R-68-1 (part), § 284-30-010, filed 4/23/68, effective 10/1/68.] Repealed by WSR 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
284-30-100	Title and explanation. [Order R-71-1, § 284-30-100, filed 6/15/71, effective 9/1/71.] Repealed by WSR 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
284-30-110	Purpose. [Order R-71-1, § 284-30-110, filed 6/15/71, effective 9/1/71.] Repealed by WSR 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.

284-30-120 Replacement of life insurance defined. [Order R-71-1, § 284-30-120, filed 6/15/71, effective 9/1/71.] Repealed by WSR 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.

284-30-130 Exemptions. [Order R-71-1, § 284-30-130, filed 6/15/71, effective 9/1/71.] Repealed by WSR 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.

284-30-140 Duties of licensees. [Order R-71-1, § 284-30-140, filed 6/15/71, effective 9/1/71.] Repealed by WSR 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.

284-30-150 Duties of insurers. [Order R-71-1, § 284-30-150, filed 6/15/71, effective 9/1/71.] Repealed by WSR 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.

284-30-160 Enforcement. [Order R-71-1, § 284-30-160, filed 6/15/71, effective 9/1/71.] Repealed by WSR 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.

284-30-170 Forms. [Order R-71-1, § 284-30-170, filed 6/15/71, effective 9/1/71.] Repealed by WSR 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.

284-30-180 Supersedes prior regulation. [Order R-71-1, § 284-30-180, filed 6/15/71, effective 9/1/71.] Repealed by WSR 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.

284-30-190 Severability. [Order R-71-1, § 284-30-190, filed 6/15/71, effective 9/1/71.] Repealed by WSR 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.

284-30-200 Effective date. [Order R-71-1, § 284-30-200, filed 6/15/71, effective 9/1/71.] Repealed by WSR 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.

284-30-3901 Definitions for settlement of vehicle claims. [Statutory Authority: RCW 48.02.060, 48.30.010. WSR 03-14-092 (Matter No. R 2002-06), § 284-30-3901, filed 6/30/03, effective 10/1/03.] Repealed by WSR 09-11-129 (Matter No. R 2007-08), 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. WSR 03-14-092 (Matter No. R 2002-06), § 284-30-3902, filed 6/30/03, effective 10/1/03.] Repealed by WSR 09-11-129 (Matter No. R 2007-08), 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. WSR 03-14-092 (Matter No. R 2002-06), § 284-30-3903, filed 6/30/03, effective 10/1/03.] Repealed by WSR 09-11-129 (Matter No. R 2007-08), 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. WSR 03-14-092 (Matter No. R 2002-06), § 284-30-3904, filed 6/30/03, effective 10/1/03.] Repealed by WSR 09-11-129 (Matter No. R 2007-08), 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. WSR 03-14-092 (Matter No. R 2002-06), § 284-30-3905, filed 6/30/03, effective 10/1/03.] Repealed by WSR 09-11-129 (Matter No. R 2007-08), 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. WSR 03-14-092 (Matter No. R 2002-06), § 284-30-3906, filed 6/30/03, effective 10/1/03.] Repealed by WSR 09-11-129 (Matter No. R 2007-08), 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. WSR 03-14-092 (Matter No. R 2002-06), § 284-30-3907, filed 6/30/03, effective 10/1/03.] Repealed by WSR 09-11-129 (Matter No. R 2007-08), 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. WSR 03-14-092 (Matter No. R 2002-06), § 284-30-3908, filed 6/30/03, effective 10/1/03.] Repealed by WSR 09-11-129 (Matter No. R 2007-08), 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. WSR 03-14-092 (Matter No. R 2002-06), § 284-30-3909, filed 6/30/03, effective 10/1/03.] Repealed by WSR 09-11-129 (Matter No. R 2007-08), 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. WSR 03-14-092 (Matter No. R 2002-06), § 284-30-3910, filed 6/30/03, effective 10/1/03.] Repealed by WSR 09-11-129 (Matter No. R 2007-08), 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. WSR 03-14-092 (Matter No. R 2002-06), § 284-30-3911, filed 6/30/03, effective 10/1/03.] Repealed by WSR 09-11-129 (Matter No. R 2007-08), 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. WSR 04-01-176 (Matter No. R 2003-07), § 284-30-3912, filed 12/23/03, effective 1/23/04; WSR 03-14-092 (Matter No. R 2002-06), § 284-30-3912, filed 6/30/03, effective 10/1/03.] Repealed by WSR 09-11-129 (Matter No. R 2007-08), 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. WSR 03-14-092 (Matter No. R 2002-06), § 284-30-3913, filed 6/30/03, effective 10/1/03.] Repealed by WSR 09-11-129 (Matter No. R 2007-08), 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. WSR 03-14-092 (Matter No. R 2002-06), § 284-30-3914, filed 6/30/03, effective 10/1/03.] Repealed by WSR 09-11-129 (Matter No. R 2007-08), 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. WSR 03-14-092 (Matter No. R 2002-06), § 284-30-3915, filed 6/30/03, effective 10/1/03.] Repealed by WSR 09-11-129 (Matter No. R 2007-08), 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. WSR 03-14-092 (Matter No. R 2002-06), § 284-30-3916, filed 6/30/03, effective 10/1/03.] Repealed by WSR 09-11-129 (Matter No. R 2007-08), 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. WSR 78-08-082 (Order R 78-3), § 284-30-410, filed 7/27/78, effective 9/1/78.] Repealed by WSR 09-11-129 (Matter No. R 2007-08), 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). WSR 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). WSR 88-11-056 (Order R 88-6), § 284-30-800, filed 5/17/88.] Repealed by WSR 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.
- 284-30-990 Exhibit 1—Disclosure statement. [Exhibit 1 is part of Washington Administrative Code Order R-71-1 (codified as WAC 284-30-990), filed 6/15/71, effective 9/1/71.] Repealed by WSR 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
- 284-30-991 Exhibit 2—Notice to applicants regarding replacement of life insurance. [Exhibit 2 is part of Washington Administrative Code Order R-71-1 (codified as WAC 284-30-991), filed 6/15/71, effective 9/1/71.] Repealed by WSR 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.

THE UNFAIR CLAIMS SETTLEMENT PRACTICES REGULATION

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. WSR 09-11-129 (Matter No. R 2007-08), § 284-30-300, filed 5/20/09, effective 8/21/09; WSR 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. WSR 09-11-129 (Matter No. R 2007-08), § 284-30-310, filed 5/20/09, effective 8/21/09; WSR 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) "Documented expenses" means specific incurred expenses which are either paid by the group policyholder or paid on behalf of the group policyholder and for which documentation is obtained by the insurer. Such documented expenses include, but are not limited to, training, marketing, consumer awareness, information technology and computer programming and operations and administration. Such expenses must be specifically disbursed and actually incurred within the limits set forth in the policy or policy addendum.

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

(7) "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.

(8) "Group policyholder" means a policy owner under a group policy which provides coverage to an entire group of fifty-one or more individuals.

(9) "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.

(10) "Insurer" means any individual, corporation, association, partnership, reciprocal exchange, interinsurer, 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.

(11) "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.

(12) "Loss vehicle" means the damaged motor vehicle or a motor vehicle that the insurer determines is a "total loss."

(13) "Motor vehicle" means any vehicle subject to registration under chapter 46.16 RCW.

(14) "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.

(15) "Principally garaged area" means the place where the loss vehicle is normally kept, consistent with the applicable policy of insurance.

(16) "Shall describe any such payment" means the specific expenses that are described in the group policyholder's contract or subsequent contract addendum with the insurer and which establish the limits of acceptable expenses under the contract.

(17) "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.

(18) "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.

(19) "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 48.43.715. WSR 20-24-070, § 284-30-320, filed 11/24/20, effective 12/25/20. Statutory Authority: RCW 48.02.060 and 48.30.010. WSR 09-11-129 (Matter No. R 2007-08), § 284-30-320, filed 5/20/09, effective 8/21/09; WSR 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 payment, whether by check, draft, electronic funds transfer, prepaid card, or other method of electronic payment 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. WSR 16-20-050 (Matter No. R 2016-12), § 284-30-330, filed 9/29/16, effective 10/30/16; WSR 09-11-129 (Matter No. R 2007-08), § 284-30-330, filed 5/20/09, effective 8/21/09. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. WSR 87-09-071 (Order R 87-5), § 284-30-330, filed 4/21/87. Statutory Authority: RCW 48.02.060 and 48.30.010. WSR 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. WSR 09-11-129 (Matter No. R 2007-08), § 284-30-340, filed 5/20/09, effective 8/21/09; WSR 78-08-082 (Order R 78-3), § 284-30-340, filed 7/27/78, effective 9/1/78.]

WAC 284-30-350 Misrepresentation of policy provisions. (1) No insurer shall fail to fully disclose to first party claimants all pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented.

(2) No insurance producer or title insurance agent shall conceal from first party claimants benefits, coverages or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim.

(3) No insurer shall deny a claim for failure to exhibit the property without proof of demand and unfounded refusal by a claimant to do so.

(4) No insurer shall, except where there is a time limit specified in the policy, make statements, written or otherwise, requiring a claimant to give written notice of loss or proof of loss within a specified time limit and which seek to relieve the company of its obligations if such a time limit is not complied with unless the failure to comply with such time limit prejudices the insurer's rights.

(5) No insurer shall request a first party claimant to sign a release that extends beyond the subject matter that gave rise to the claim payment.

(6) No insurer shall issue checks or drafts in partial settlement of a loss or claim under a specific coverage which contain language which release the insurer or its insured from its total liability.

(7) No insurer shall make a payment of benefits without clearly advising the payee, in writing, that it may require reimbursement, when such is the case.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.010(5). WSR 11-01-159 (Matter No. R 2010-09), § 284-30-350, filed 12/22/10, effective 1/22/11. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. WSR 87-09-071 (Order R 87-5), § 284-30-350, filed 4/21/87. Statutory Authority: RCW 48.02.060 and 48.30.010. WSR 78-08-082 (Order R 78-3), § 284-30-350, filed 7/27/78, effective 9/1/78.]

WAC 284-30-355 Certificates of insurance. (1) The following definitions apply to this section.

(a) "Certificate" or "certificate of insurance" means any document, without regard to title or description, that is issued by an insurer, insurance producer, or surplus line broker as evidence of property or casualty insurance coverage. Certificate or certificate of insurance as used in this section does not include an insurance policy, insurance binder, an automobile insurance identification or information card, or a certificate issued to a person or entity that has purchased coverage under a group master policy.

(b) "Certificate holder" means any person, other than a policyholder, that requests, obtains, or possesses a certificate.

(c) "Property" means the insurance coverages described in RCW 48.11.040.

(d) "Casualty" means the insurance coverages described in RCW 48.11.070.

(e) "Insurance binder" means a temporary document that serves as evidence of insurance until the insurance policy is issued.

(f) "Insurance policy" means the executed insurance policy issued to the named insured as part of an insurance transaction as defined in RCW 48.01.060.

(2) This section applies to all:

(a) Certificate holders, policyholders, insurers, insurance producers, surplus line brokers; and

(b) Certificates issued as evidence of insurance coverage for risks located in this state without regard to where a certificate holder, policyholder, insurer, insurance producer, or surplus line broker is located.

(3)(a) If a certificate holder is named within the policy or endorsement and the policy or endorsement requires notice to be provided to the certificate holder, a certificate holder only possesses a right to notice of:

(i) Cancellation;

(ii) Nonrenewal; or

(iii) A material change, or any similar notice concerning the insurance policy.

(b) The insurance policy governs the terms and conditions of the notice, including the timing of the notice.

(4) No person may knowingly demand or require an insurer, insurance producer, surplus line broker, or policyholder to issue a certificate that contains any false or misleading information or that purports to alter, amend, or extend the coverage provided by the insurance policy.

(5) No person may knowingly issue or circulate a certificate that contains any false or misleading information or that purports to alter, amend, or extend the coverage provided by the insurance policy.

(6) No person may issue, demand, or require, either in addition to or in lieu of a certificate, a document that contains any false or misleading information or that purports to alter, amend, or extend the coverage provided by the insurance policy.

(7)(a) Nothing in this section affects or excuses a person's obligation to obtain an insurance policy for the benefit of a third party that conforms to specific contractual or legal requirements.

(b) Notwithstanding any requirement, term, or condition of any contract, the insurance coverage provided by the referenced policy of insurance is subject to all the terms, exclusions, and conditions of

the policy. A certificate of insurance does not confer new or additional rights beyond what the referenced policy of insurance provides.

[Statutory Authority: RCW 48.02.060. WSR 12-09-052 (Matter No. R 2011-30), § 284-30-355, filed 4/16/12, effective 5/17/12.]

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, acknowledgment by payment constitutes a satisfactory response.

(b) If an acknowledgment is made by means other than writing, an appropriate notation of the acknowledgment 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 using the commissioner's electronic company complaint system.

(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, 48.44.050, 48.46.200, and 48.30.010. WSR 13-12-079 (Matter No. R 2013-05), § 284-30-360, filed 6/5/13, effective 1/1/14. Statutory Authority: RCW 48.02.060 and 48.30.010. WSR 09-11-129 (Matter No. R 2007-08), § 284-30-360, filed 5/20/09, effective 8/21/09; WSR 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. WSR 09-11-129 (Matter No. R 2007-08), § 284-30-370, filed 5/20/09, effective 8/21/09; WSR 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. WSR 09-11-129 (Matter No. R 2007-08), § 284-30-380, filed 5/20/09, effective 8/21/09; WSR 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. WSR 09-11-129 (Matter No. R 2007-08), § 284-30-390, filed 5/20/09, effective 8/21/09;

WSR 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. WSR 87-09-071 (Order R 87-5), § 284-30-390, filed 4/21/87. Statutory Authority: RCW 48.02.060 (3)(a). WSR 85-02-019 (Order R 84-8), § 284-30-390, filed 12/27/84. Statutory Authority: RCW 48.02.060 and 48.30.010. WSR 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 database 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. WSR 09-11-129 (Matter No. R 2007-08), § 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. WSR 09-11-129 (Matter No. R 2007-08), § 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. Any recoveries must be allocated first to the insured for any deductible(s) incurred in the loss, less applicable comparable fault. 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. WSR 11-13-029 (Matter No. R 2010-15), § 284-30-393, filed 6/7/11, effective 7/8/11. Statutory Authority: RCW 48.02.060 and 48.30.010. WSR 09-11-129 (Matter No. R 2007-08), § 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. WSR 09-11-129 (Matter No. R 2007-08), § 284-30-394, filed 5/20/09, effective 8/21/09.]

WAC 284-30-395 Standards for prompt, fair and equitable settlements applicable to automobile personal injury protection insurance. The commissioner finds that some insurers limit, terminate, or deny coverage for personal injury protection insurance without adequate disclosure to insureds of their bases for such actions. To eliminate unfair acts or practices in accord with RCW 48.30.010, the following

are hereby defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance specifically applicable to automobile personal injury protection insurance. The following standards apply to an insurer's consultation with health care professionals when reviewing the reasonableness or necessity of treatment of the insured claiming benefits under his or her automobile personal injury protection benefits in an automobile insurance policy, as those terms are defined in RCW 48.22.005 (1), (7), and (8), and as prescribed at RCW 48.22.085 through 48.22.100. This section applies only where the insurer relies on the medical opinion of health care professionals to deny, limit, or terminate medical and hospital benefit claims. When used in this section, the term "medical or health care professional" does not include an insurer's claim representatives, adjusters, or managers or any health care professional in the direct employ of the insurer.

(1) Within a reasonable time after receipt of actual notice of an insured's intent to file a personal injury protection medical and hospital benefits claim, and in every case prior to denying, limiting, or terminating an insured's medical and hospital benefits, an insurer shall provide an insured with a written explanation of the coverage provided by the policy, including a notice that the insurer may deny, limit, or terminate benefits if the insurer determines that the medical and hospital services:

- (a) Are not reasonable;
- (b) Are not necessary;
- (c) Are not related to the accident; or
- (d) Are not incurred within three years of the automobile accident.

These are the only grounds for denial, limitation, or termination of medical and hospital services permitted pursuant to RCW 48.22.005(7), 48.22.095, or 48.22.100.

The written explanation responsive to an insured's intent to file a personal injury protection medical and hospital benefits claim must also include contact information for the office of the Washington state insurance commissioner's consumer protection services, including the consumer protection division's hotline phone number and the agency's website address, and a statement that the consumer may contact the office of the insurance commissioner for assistance with questions or complaints.

(2) Within a reasonable time after an insurer concludes that it intends to deny, limit, or terminate an insured's medical and hospital benefits, the insurer shall provide an insured with a written explanation that describes the reasons for its action and copies of pertinent documents, if any, upon request of the insured. The insurer shall include the true and actual reason for its action as provided to the insurer by the medical or health care professional with whom the insurer consulted in clear and simple language, so that the insured will not need to resort to additional research to understand the reason for the action. A simple statement, for example, that the services are "not reasonable or necessary" is insufficient.

(3)(a) Health care professionals with whom the insurer will consult regarding its decision to deny, limit, or terminate an insured's medical and hospital benefits shall be currently licensed, certified, or registered to practice in the same health field or specialty as the health care professional that treated the insured.

(b) If the insured is being treated by more than one health care professional, the review shall be completed by a professional li-

censed, certified, or registered to practice in the same health field or specialty as the principal prescribing or diagnosing provider, unless otherwise agreed to by the insured and the insurer. This does not prohibit the insurer from providing additional reviews of other categories of professionals.

(4) To assist in any examination by the commissioner or the commissioner's delegatee, the insurer shall maintain in the insured's claim file sufficient information to verify the credentials of the health care professional with whom it consulted.

(5) An insurer shall not refuse to pay expenses related to a covered property damage loss arising out of an automobile accident solely because an insured failed to attend, or chose not to participate in, an independent medical examination requested under the insured's personal injury protection coverage.

(6) If an automobile liability insurance policy includes an arbitration provision, it shall conform to the following standards:

(a) The arbitration shall commence within a reasonable period of time after it is requested by an insured.

(b) The arbitration shall take place in the county in which the insured resides or the county where the insured resided at the time of the accident, unless the parties agree to another location.

(c) Relaxed rules of evidence shall apply, unless other rules of evidence are agreed to by the parties.

(d) The arbitration shall be conducted pursuant to arbitration rules similar to those of the American Arbitration Association, the Center for Public Resources, the Judicial Arbitration and Mediation Service, Washington Arbitration and Mediation Service, chapter 7.04 RCW, or any other rules of arbitration agreed to by the parties.

[Statutory Authority: RCW 48.02.060 and 48.22.105. WSR 12-19-081 (Matter No. R 2012-13), § 284-30-395, filed 9/18/12, effective 4/1/13. Statutory Authority: RCW 48.02.060, 48.22.105 and 48.30.010. WSR 97-13-005 (Matter No. R 96-6), § 284-30-395, filed 6/5/97, effective 7/6/97.]

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. WSR 09-11-129 (Matter No. R 2007-08), § 284-30-400, filed 5/20/09, effective 8/21/09; WSR 78-08-082 (Order R 78-3), § 284-30-400, filed 7/27/78, effective 9/1/78.]

WAC 284-30-450 Insurance policies and contracts—Coverage for drugs. (1) Authority and purpose.

(a) Some insurers deny payment for drugs that have been approved by the Federal Food and Drug Administration (FDA) when the drugs are used for indications other than those stated in the labelling approved by the FDA (off-label use) while other insurers with similar coverage terms pay for off-label use. Denial of payment for off-label use can interrupt or effectively deny access to necessary and appropriate treatment for a person being treated for a life-threatening illness.

(b) Equity among insured residents of this state and fair claims settlement practices and fair competition among companies providing coverage to residents of this state require comparable reimbursement for prescribed drugs among insurers, health care service contractors, and health maintenance organizations.

(c) Use of off-label indications often provides efficacious drugs at a lower cost.

(d) To prevent unfair methods of claims settlements, unfair competition, and unfair or deceptive acts or practices of insurers and prohibited acts or practices of health care service contractors or health maintenance organizations, this rule is adopted.

(2) Scope.

This regulation affects all insurance and health benefit policies and contracts providing coverage for drugs to a resident of this state which are issued, amended, delivered or renewed on or after January 1, 1995.

(3) Definitions. The following definitions are used in this section:

(a) "Drug" or "drugs" means any substance prescribed by a physician taken by mouth, injected into a muscle, the skin, a blood vessel, or a cavity of the body, or applied to the skin to treat or prevent a disease, and specifically includes drugs or biologicals used in an anticancer chemotherapeutic regimen for a medically accepted indication or for the treatment of people with HIV or AIDS.

(b) "Off-label" means the prescribed use of a drug which is other than that stated in its FDA approved labelling.

(c) "Peer-reviewed medical literature" means scientific studies printed in journals or other publications in which original manuscripts are published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. Peer-reviewed medical literature does not include in-house publications of pharmaceutical manufacturing companies.

(d) "Physician" means a medical doctor or other health care provider acting within the scope of his or her professional license.

(e) "Policy" or "contract" means any individual, group or blanket policy of insurance or health benefit contract issued by a disability insurer, health care service contractor, or health maintenance organization which is issued, amended, delivered or renewed on or after January 1, 1995, and which provides coverage for drugs to a resident of this state.

(f) "Standard reference compendia" means:

(i) The American Hospital Formulary Service-Drug Information;

(ii) The American Medical Association Drug Evaluation;

(iii) The United States Pharmacopoeia-Drug Information; or

(iv) Other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services or the insurance commissioner.

(4) Standards of coverage.

(a) No insurance policy or contract which provides coverage for prescription drugs to a resident of this state shall exclude coverage of any such drug for a particular indication on the grounds that the drug has not been approved by the Federal Food and Drug Administration for that indication, if such drug is recognized as effective for treatment of such indication:

(i) In one of the standard reference compendia;

(ii) In the majority of relevant peer-reviewed medical literature if not recognized in one of the standard reference compendia; or

(iii) By the Federal Secretary of Health and Human Services.

(b) Coverage of a prescription drug required by this section shall also include medically necessary services associated with the administration of the drug.

(c) This regulation shall not be construed to require coverage for any drug when the Federal Food and Drug Administration has determined its use to be contra-indicated.

(d) This regulation shall not be construed to require coverage for experimental drugs not otherwise approved for any indication by the Federal Food and Drug Administration.

[Statutory Authority: RCW 48.01.030, 48.02.060 and 48.30.010. WSR 94-18-038 (Order R 94-17), § 284-30-450, filed 8/30/94, effective 9/30/94.]

TRADE PRACTICES

WAC 284-30-500 Unfair practices with respect to vehicle insurance. (1) The following practices by any insurer with respect to every vehicle liability insurance policy applicable to private passenger automobiles registered or principally garaged in this state are unfair and prohibited:

(a) Failing to provide, to any insured under such policy, liability limits at least as great as those required by RCW 46.29.090, as measured at the effective date of the applicable policy or its renewal;

(b) Denying or limiting liability coverage in such policy to less than the insured's policy limits solely because the injured person qualifies as an insured as defined in RCW 48.22.005 (5) (a);

(c) Denying or limiting liability coverage in such policy, with respect to injuries sustained by motorcycle passengers, to an amount below the bodily injury liability limits required by RCW 46.29.090, if the policy provides liability coverage for an insured's ownership, operation, or use of a motorcycle.

(2) With respect to vehicle insurance policies applicable to private passenger vehicles registered or principally garaged in this state, failing to provide a named insured an itemization of the premium costs for the coverages under the policy if there are identifiable separate premium charges for the coverages is unfair and prohibited. The required itemization must be given to a named insured no later than at the time of delivery of a policy and must accompany each offer to renew thereafter.

(3) It is an unfair practice for any insurer to consider traffic violations or accidents which occurred more than three years in the past, with respect to the acceptance, rejection, cancellation or non-renewal of any insured under a private passenger automobile insurance policy, unless, because of the individual's violations, accidents or driving record during the three years immediately past, the earlier violations or accidents are significantly relevant to the individual's qualifications for insurance.

(4) For purposes of this section, the definition of a "private passenger automobile" is: (a) That set forth in RCW 48.18.297, including a motorcycle except as otherwise specifically provided in this section; or (b) a personal vehicle with a private passenger automobile

policy with a rider or endorsement as described in RCW 48.177.010 (2) (a).

[Statutory Authority: RCW 48.020.060 [48.02.060] and 48.177.010. WSR 16-03-021 (Matter No. R 2015-13), § 284-30-500, filed 1/8/16, effective 2/8/16. Statutory Authority: RCW 48.02.060. WSR 12-03-060 (Matter No. R 2011-22), § 284-30-500, filed 1/12/12, effective 2/12/12; WSR 07-19-106 (Matter No. R 2007-07), § 284-30-500, filed 9/19/07, effective 10/20/07. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. WSR 87-09-071 (Order R 87-5), § 284-30-500, filed 4/21/87. Statutory Authority: RCW 48.02.060 (3) (a). WSR 85-02-019 (Order R 84-8), § 284-30-500, filed 12/27/84.]

WAC 284-30-550 Receipts to be given. (1) To effectuate RCW 48.17.470 and 48.17.480 and to eliminate unfair practices in accord with RCW 48.30.010, any insurance producer or other representative of an insurer who receives a contract payment or premium from or on behalf of an insured or applicant for homeowners', dwelling fire, private passenger automobile, motorcycle, individual life, or individual disability insurance shall deliver or mail a signed receipt therefor as promptly as possible, which should generally be no later than the next business day. Such receipt must be dated, identify the insurance producer and the insurance producer's address, identify the person by or for whom payment is made, state the amount received, identify the applicable insurer by its full legal name (or the premium finance company or Washington automobile insurance plan if payment is intended therefor), and identify the contract or policy including a brief description of the coverage for which payment is received.

(2) The receipt need not be an independent document but may be incorporated in an application or binder, if appropriate.

(3) For purposes of this section "life insurance" includes annuities.

(4) For purposes of this section "insurer" includes a health care service contractor and a health maintenance organization, and "disability insurance" includes their contracts and agreements.

(5) This section shall not apply to the receipt of checks or other instruments payable on their face to the insurer, premium finance company or the Washington Automobile Insurance Plan. It also shall not apply to payments (other than by cash) received by an insurance producer after delivery of the policy for which payment is made, when the payment is pursuant to a premium financing arrangement with the insurance producer or in response to a billing by the insurance producer.

(6) A failure to comply with this section shall be an unfair practice pursuant to RCW 48.30.010, and a violation of a regulation pursuant to RCW 48.17.530.

(7) Each insurer shall inform its insurance producers and appropriate representatives of the requirements of this section.

[Statutory Authority: RCW 48.02.060 (3) (a) and 48.17.010(5). WSR 11-01-159 (Matter No. R 2010-09), § 284-30-550, filed 12/22/10, effective 1/22/11. Statutory Authority: RCW 48.02.060 (3) (a). WSR 85-02-019 (Order R 84-8), § 284-30-550, filed 12/27/84.]

WAC 284-30-560 Applications and binders. (1) Every application form used in connection with homeowners', dwelling fire and vehicle

insurance, shall contain a clear and conspicuous statement setting forth whether or not coverage has commenced.

(a) If coverage has commenced, the effective date shall be stated.

(b) If coverage has not commenced, there shall be an explanation as to the circumstances which will cause coverage to commence and the time when coverage will become effective.

(c) The statement concerning commencement of coverage shall not be minimized, rendered obscure, or presented in an ambiguous fashion or intermingled with the other contents of the application so as to be confusing, misleading or not readily evident.

(d) A copy of such application shall be delivered or mailed to the applicant promptly following its execution.

(2) Every binder used pending the issuance of a policy of property, marine and transportation, vehicle and general casualty insurance, as those kinds of insurance are defined in chapter 48.11 RCW, shall be reduced to writing or printed form and delivered or mailed to the insured as promptly as possible, which should generally be no later than the next business day.

(a) Such binder must be dated, identify the insurer in which coverage is bound, briefly describe the coverage bound, state the date and time coverage is effective, and acknowledge receipt of the amount of any premium money received.

(b) Such binder may be incorporated in or be attached to the application for the insurance but must be clear and conspicuous.

(3) Binders should be replaced promptly with insurance policies. With few exceptions and then only in compliance with RCW 48.18.230(2), insurers must replace binders within ninety days of their effective date.

(4) It shall be an unfair practice and unfair competition for an insurer or insurance producer to engage in acts or practices which are contrary to or not in conformity with the requirements of this section, and a violation of this section is prohibited and shall subject an insurer and insurance producer to the penalties or procedures set forth in RCW 48.05.140, 48.17.530, or 48.30.010.

(5) Each insurer shall inform its insurance producers and appropriate representatives of the requirements of this section.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.010(5). WSR 11-01-159 (Matter No. R 2010-09), § 284-30-560, filed 12/22/10, effective 1/22/11. Statutory Authority: RCW 48.02.060 (3)(a). WSR 85-02-019 (Order R 84-8), § 284-30-560, filed 12/27/84.]

WAC 284-30-570 Actual reason for canceling, denying or refusing to renew insurance to be disclosed. Whenever an insurer is required by law to give the reason for its canceling, denying, or refusing to renew insurance, as, for example, pursuant to RCW 48.18.291, 48.18.292, or 48.30.320, it shall give the true and actual reason for its action in clear and simple language, so that the insured or applicant will not need to resort to additional research to understand the real reason for the action. It is not sufficient, for example, to state that an insured "does not meet the company's underwriting standards." The reason why the individual does not meet such underwriting standards is what must be given. If the actual reason relates to medical information, the insurer may make a broad reference thereto and

limit specific disclosure of details to the applicant's or insured's physician.

[Statutory Authority: RCW 48.02.060 (3)(a). WSR 85-02-019 (Order R 84-8), § 284-30-570, filed 12/27/84.]

WAC 284-30-572 Discrimination prohibited. (1) It shall be an unfair practice for any insurer to decline, cancel, or refuse to renew any homeowners, dwelling fire or vehicle insurance policy, or to vary its terms, rates, conditions or benefits, because of an insured's or applicant's race, creed, color, national origin, religion, or ability to read, write, or speak the English language.

(2) It is an unfair practice for any insurer, and a prohibited practice for any health care service contractor or health maintenance organization, to discourage a claimant or an insured from contacting the insurance commissioner, or to unfairly discriminate against such person because of such contact.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. WSR 87-09-071 (Order R 87-5), § 284-30-572, filed 4/21/87.]

WAC 284-30-574 Insurer must make independent evaluation. It shall be an unfair practice for any insurer to rely solely on another insurer's denial, cancellation, or nonrenewal of insurance to support a denial or termination of coverage. In every case, an insurer must go behind another insurer's action and make its own independent decision on the merits. This section does not prohibit an insurer from denying a binder pending its evaluation of another insurer's action, and does not apply to an insurer-reinsurer relationship.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. WSR 87-09-071 (Order R 87-5), § 284-30-574, filed 4/21/87.]

WAC 284-30-580 Policies to be delivered, not held by insurance producers or title insurance agents. (1) RCW 48.18.260 requires that policies be delivered within a reasonable period of time after issuance. If an insurer relies upon its appointed insurance producers or title insurance agents to make deliveries of its policies, the insurer, as well as the appointed insurance producer or title insurance agent, is responsible for any delay resulting from the failure of the appointed insurance producer or title insurance agent to act diligently.

(2) Insurance producers and title insurance agents delivering insurance policies to insureds must make an actual physical delivery. It is not acceptable for an insurance producer or title insurance agent to merely obtain a receipt indicating a delivery and then to retain the policy, for safekeeping or otherwise, in the insurance producer's or title insurance agent's possession.

(3) Insurance producers and title insurance agents may obtain policies from owners or insureds and hold such policies briefly for analysis or servicing, giving a receipt therefor in every instance, but shall promptly return any such policies to their owners or insureds. Insurance producers and title insurance agents shall not otherwise take custody of, or hold, insurance policies, whether for fee or

at no charge, unless a family or legal relationship clearly justifies such conduct, as, for example, where a policy belonging to a minor child of the insurance producer and title insurance agent is held, or where the insurance producer or title insurance agent is acting as a legal guardian or a court appointed representative and holds a policy of a ward or of an estate.

(4) It shall be an unfair practice and unfair competition for an insurer or insurance producer or title insurance agent to engage in acts or practices which are contrary to or not in conformity with the requirements of this section, and a violation of this section is prohibited and shall subject an insurer, insurance producer and title insurance agent to the penalties or procedures set forth in RCW 48.05.140, 48.17.530, or 48.30.010.

(5) Each insurer shall inform its appointed insurance producers or title insurance agents and appropriate representatives of the requirements of this section.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.010(5). WSR 11-01-159 (Matter No. R 2010-09), § 284-30-580, filed 12/22/10, effective 1/22/11. Statutory Authority: RCW 48.02.060 (3)(a). WSR 85-02-019 (Order R 84-8), § 284-30-580, filed 12/27/84.]

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 email;

(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, WSR 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. WSR 87-09-071 (Order R 87-5), § 284-30-590, filed 4/21/87.]

WAC 284-30-595 Unfair practices regarding documented expenses for implementation credits. Under RCW 48.30.140 and 48.30.150, an insurer or health carrier may issue payment to offset a documented expense that is incurred by a group policyholder in changing coverages from one insurer or health carrier to another provided that the insurer or health carrier maintains evidence of the documented expense for three years from the date of the expense. An insurer or health carrier will describe in the policy or in any such filing with the commissioner that the payment made to the group policyholder will not exceed the amount of the documented expenses.

(1) The failure to maintain and document an expense incurred by a group policyholder constitutes an unfair trade practice and is a violation of this chapter.

(2) Upon the commissioner's request, the insurer or health carrier must provide proof of a documented expense in the form of paper or electronic copy.

(3) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Health carrier" has the same meaning as in RCW 48.43.005.

(b) "Insurer" has the same meaning as in RCW 48.01.050.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. WSR 21-11-064, § 284-30-595, filed 5/14/21, effective 6/14/21. Statutory Authority: RCW 48.02.060 and 48.43.715. WSR 20-24-070, § 284-30-595, filed 11/24/20, effective 12/25/20.]

WAC 284-30-600 Unfair practices with respect to out-of-state group life and disability insurance. (1) Under RCW 48.30.010, it is an unfair method of competition and an unfair practice for any insurer to engage in any insurance transaction, as defined in RCW 48.01.060, regarding life insurance, annuities, or disability insurance coverage on individuals in this state under a group policy delivered to a policyholder outside this state when:

(a) The policy or certificate providing coverage in the state of Washington, including, but not limited to, applications, riders, or endorsements, contains any inconsistent, ambiguous or misleading clauses, or exceptions and conditions which unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the policy or certificate.

(b) The policy or certificate providing coverage in the state of Washington, including, but not limited to, applications, riders, or endorsements, has any title, heading, or other indication of its provisions which is misleading.

(c) The policy or certificate delivered to residents of the state of Washington does not include all terms and conditions of the coverage.

(d) The type of group being covered under the contract providing coverage in the state of Washington does not qualify for group life insurance or group disability insurance under the provisions of Title 48 RCW.

(e) The coverage is being solicited by deceptive advertising.

(f) With respect to disability insurance, the policy or certificate providing coverage in the state of Washington does not:

(i) Provide that claims will be processed in compliance with RCW 48.21.130 through 48.21.148;

(ii) Meet the requirements as to benefits and coverage mandated by chapter 48.21 RCW and rules effectuating that chapter, specifically including those set forth in chapter 284-51 WAC, and WAC 284-30-610, 284-30-620 and 284-30-630;

(iii) With respect to long-term care insurance, also meet the requirements of chapter 48.84 RCW and chapter 284-54 WAC;

(iv) With respect to medicare supplemental insurance, also meet the requirements of chapter 48.66 RCW and chapter 284-66 WAC; and

(v) Meet the loss ratio standards applicable to group insurance under RCW 48.66.100 and 48.70.030 and chapter 284-60 WAC.

(g) With respect to life insurance, the out-of-state group policy or certificate providing coverage in the state of Washington fails to comply with the provisions of:

(i) Chapter 48.24 RCW;

(ii) WAC 284-23-550 and 284-23-600 through 284-23-730;

(iii) WAC 284-30-620; and

(iv) WAC 284-30-630.

(2) Except as provided in subsection (3)(c) of this section, for purposes of this section it is immaterial whether the coverage is offered by means of a solicitation through: A sponsoring organization; the mail broadcast or print media; electronic communication, including electronic mail and websites; licensed insurance producers; or any other method of communication.

(3) It is further defined to be an unfair practice for any insurer marketing group insurance coverage in this state to do the following with respect to the coverage:

(a) To fail to comply with the requirements of this state relating to advertising and claims settlement practices, and to fail to furnish the commissioner, upon request, copies of all advertising materials intended for use in this state;

(b) To fail to file copies of all certificate forms and any other related forms providing coverage in Washington, including trust documents or articles of incorporation with the commissioner at least thirty days prior to use; and

(c) To fail to file with the commissioner a copy of the disclosure statement required by WAC 284-30-610, where the sale of coverage to individuals in this state will be through solicitation by insurance producers. The disclosure statement must be appropriately completed, as it appears when delivered to the Washington individuals who are solicited by the Washington licensees.

The disclosure form must also be filed at least thirty days prior to any solicitation of coverage.

(4) This section does not apply to self-funded plans that are defined by and subject to the federal Employee Retirement Income Security Act of 1974 (ERISA) or to insurers when acting as third-party administrators for self-funded ERISA plans.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.010(5). WSR 11-01-159 (Matter No. R 2010-09), § 284-30-600, filed 12/22/10, effective 1/22/11. Statutory Authority: RCW 48.02.060, 48.30.010, 48.01.020, 48.01.060. WSR 00-19-048 (Matter R 98-18), § 284-30-600, filed 9/14/00, effective 10/15/00. Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010. WSR 91-03-073 (Order 90-14), § 284-30-600, filed 1/16/91, effective 4/1/91. Statutory Authority: RCW 48.02.060 (3)(a). WSR 85-02-018 (Order R 84-7), § 284-30-600, filed 12/27/84.]

WAC 284-30-610 Unfair practices with respect to the solicitation of coverage under out-of-state group policies. (1) It is an unfair method of competition and an unfair practice for an insurer to permit a licensed insurance producer, whether appointed by the insurer or not, to solicit an individual in the state of Washington to buy or apply for life insurance, annuities, or disability insurance coverage when the coverage is provided under the terms of a group policy delivered to an association or organization (or to a trustee designated by the association or organization), as policyholder, outside this state, unless the following steps are taken:

(a) An accurately completed disclosure statement, substantially in the form set forth in subsection (2) of this section, must be brought to the attention of the individual being solicited before the application for coverage is completed and signed. The disclosure form must be signed by both the soliciting licensee and the individual being solicited and it must be given to the individual.

(b) A copy of the completed disclosure statement must be submitted by the soliciting licensee, with the application for coverage, to the insurer providing the coverage.

(c) The insurer must confirm the accuracy of the form's contents, and retain the copy for not less than three years from the date the coverage commences or from the date received, whichever is later.

(2) Disclosure statement form: (Type size to be no less than ten-point)

(Insurer's name and address)

IMPORTANT INFORMATION ABOUT THE COVERAGE YOU ARE BEING OFFERED

Save this statement! It may be important to you in the future. The Washington State Insurance Commissioner requires that we give you the following information about the coverage offered to you under a group policy issued by (insurer) , (to/on behalf of) (association or organization) .

The policy is subject to and governed by the laws of the state of

The certificate of coverage issued to you is governed by the state of Washington.

The Washington State Insurance Commissioner has authority to assist you concerning your coverage.

To keep this coverage, you _____(must/need not)_____ continue membership in the group. If you are not now a member, the initial cost of membership is \$ Additional dues or membership fees are currently \$ per Membership costs _____(may/will not)_____ increase in future years. You will also have the premiums to pay.

The coverage _____(can/can not)_____ be discontinued by the group. It _____(can/can not)_____ be terminated by the insurer. If the group organization ceases to exist, your coverage _____(would/would not)_____ terminate. You _____(are/are not)_____ entitled by the contract to convert your coverage to your own policy.

_____(Group organization's name)_____ (will/will not)_____ be paid for its participation in this insurance program. _____(An explanation of payments must be inserted here.)_____.

If you apply for this coverage, you _____(will/will not)_____ have a "free look" (of days*) during which you may cancel your contract and recover your premium without obligation. Your membership fee to join the group _____(is/is not)_____ refundable. *(Omit phrase, "of days", if there is no "free look.")

DELIVERED to the applicant this day of _____(month)_____, _____(year)_____, by

(Signed) (insurance producer).

Printed Name:

I ACKNOWLEDGE THAT I HAVE RECEIVED AND UNDERSTAND THIS DISCLOSURE STATEMENT: Applicant.

(3) This section does not apply with respect to coverage provided to individuals under a group contract which is provided for a group of a type described in RCW 48.24.035, 48.24.040, 48.24.060, 48.24.080, 48.24.090, or 48.24.095.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.010(5). WSR 11-01-159 (Matter No. R 2010-09), § 284-30-610, filed 12/22/10, effective 1/22/11. Statutory Authority: RCW 48.02.060, 48.30.010, 48.01.020, 48.01.060. WSR 00-19-048 (Matter R 98-18), § 284-30-610, filed 9/14/00, effective 10/15/00. Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010. WSR 91-03-073 (Order 90-14), § 284-30-610, filed 1/16/91, effective 4/1/91.]

WAC 284-30-620 Permissible time limit for benefits payable because of accidental injury or death. Beginning January 1, 1988, it shall be an unfair practice for any insurer to deliver a policy of insurance in this state which provides for benefits in case of accidental death or accidental injury, if it limits the benefits payable

thereunder to losses occurring within a stated period of time after the accident, unless such period of time extends for at least one year from the time of the accident. In other words, benefits for accidental death or for covered expenses incurred because of an accidental injury shall be paid if the covered death occurs, or the covered services are incurred, within one year of the accident.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. WSR 87-09-071 (Order R 87-5), § 284-30-620, filed 4/21/87.]

WAC 284-30-630 Health questions in applications to be clear and precise. If an insurer, including a health care service contractor or a health maintenance organization, intends to rely on an applicant's or enrollee's answers to health questions in an application to determine eligibility for coverage or the existence of a preexisting condition, such questions must be clear and precise. Simply asking whether the applicant has been under the care of a physician during the preceding year, for example, is not sufficient to require a "yes" answer where the applicant has been using medications that were prescribed prior to the start of the preceding year and the applicant has not seen a physician for more than a year.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. WSR 87-09-071 (Order R 87-5), § 284-30-630, filed 4/21/87.]

WAC 284-30-650 Prompt responses required. It is an unfair practice for an insurer, and a prohibited practice for a health care service contractor or a health maintenance organization, to fail to respond promptly to any inquiry from the insurance commissioner relative to the business of insurance. A lack of response within fifteen business days from receipt of an inquiry will be considered untimely. A response must be in writing, unless otherwise indicated in the inquiry. If the inquiry originates from the commissioner's electronic company complaint system, the response must be in writing and submitted using that same system. This rule also applies to any other entity or person subject to the requirements of chapter 48.30 RCW.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, and 48.30.010. WSR 20-24-041, § 284-30-650, filed 11/23/20, effective 12/24/20; WSR 13-12-079 (Matter No. R 2013-05), § 284-30-650, filed 6/5/13, effective 1/1/14. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. WSR 87-09-071 (Order R 87-5), § 284-30-650, filed 4/21/87.]

WAC 284-30-660 Deceptive use of quotations or evaluations prohibited. (1) It is an unfair or deceptive practice and an unfair method of competition pursuant to RCW 48.30.010 for any insurance company, insurance producer, surplus line broker, or title insurance agent in connection with the business of insurance, to utilize quotations or evaluations from rating or advisory services or other independent sources, in a manner likely to deceive the persons to whom the information is directed.

(2) Acts which are prohibited by this section include the following examples:

(a) If an insurer represents in its advertising that it has received an "A+" rating from an advisory service, such representation is deceptive unless it includes a clear explanation that such advisory service's practice is to rate insurance companies on the basis of "AAA," "AA," and declining to "A," if such is the case. The absence of such explanation would reasonably cause the ordinary person to believe falsely that the insurer had received the highest rating available from the service.

(b) Similarly, quoting figures or comments from a report, such as those representing claims paid or the capital or reserves or the quality of an insurer, in a manner to suggest that such figures or comments are impressive or that the report demonstrates the company to be particularly strong financially or of high quality relative to other companies, when such is not the case, creates a false impression and is deceptive.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.010(5). WSR 11-01-159 (Matter No. R 2010-09), § 284-30-660, filed 12/22/10, effective 1/22/11. Statutory Authority: RCW 48.02.060. WSR 88-24-053 (Order R 88-12), § 284-30-660, filed 12/7/88.]

WAC 284-30-670 Insurers must transact business in their legal name.

(1) Purpose and Scope. The purpose of this regulation is to adopt a long standing bulletin and a technical assistance advisory regarding the use of trade names, group names, logos or trademarks. The purpose of this regulation is also to set forth requirements to help ensure that a consumer knows the legal name of the insurer they are doing business with.

(2) Pursuant to RCW 48.30.010, the commissioner has found and hereby defines it to be an unfair practice for an insurer to conduct its business in any name other than its own legal name as required by RCW 48.05.190. Unless consumers are aware of the insurer's legal name, a consumer's policy rights and legal rights may be compromised. In addition, when consumers seek the commissioner's assistance and are not aware of the insurer's legal name, the commissioner's staff must re-search it, which unnecessarily wastes the commissioner's resources and delays the inquiry and resolution, posing a risk of harm to the consumer.

(3) When used in this regulation, "legal name" of the insurer means the name displayed on the Washington state certificate of authority issued by the commissioner.

(4) Each insurer must have standards and procedures to ensure that each consumer with whom they conduct an insurance transaction is informed of and can consistently identify the legal name of the insurer. Each insurer must provide the insurance commissioner with its standards and procedures and proof of its compliance upon request. The insurer must be able to show the legal name was provided when issuing policy documents, billing statements, and other written communications regarding policy services, underwriting, and claims and at the point during policy sales transactions when the company is determined.

(5) To assist the commissioner in identifying the legal name of the insurer, insurers' written communications to the commissioner in response to any investigation, inquiry, enforcement matter or examination must include the insurer's NAIC code.

(6) This regulation does not bar the use of trade names, logos, trademarks or group names that identify companies collectively, for

brand identification or for general purposes, but an insurer must also provide its legal name in the following situations:

- (a) When the specific insurer is known, in negotiations preliminary to the execution of an insurance contract;
- (b) In the execution of an insurance contract;
- (c) In the transaction of matters subsequent to the execution of an insurance contract and arising out of it.

(7) Violation of this regulation is not a violation for purposes of RCW 48.30.015(5).

[Statutory Authority: RCW 48.02.060. WSR 11-02-048 (Matter No. R 2010-06), § 284-30-670, filed 1/3/11, effective 2/24/11; WSR 10-12-100 (Matter No. R 2008-11), § 284-30-670, filed 6/2/10, effective 7/3/10.]

WAC 284-30-700 Restrictions as to denial and termination of homeowners insurance affected by day-care operations. (1) Beginning August 1, 1985, pursuant to RCW 48.30.010, it shall be an unfair practice for any insurer transacting homeowners insurance to deny homeowners insurance to an applicant therefor, or to terminate any homeowners insurance policy covering a dwelling located in this state, whether by cancellation or nonrenewal, for the principal reason that an insured under such policy is engaged in the operation of a day care facility, pursuant to chapter 74.15 RCW, at the insured location.

(2) This rule does not prevent an insurer from excluding or limiting coverage with respect to liability or property losses arising out of business pursuits of an insured, specifically including those related to the operation of day care facilities.

[Statutory Authority: RCW 48.02.060. WSR 85-17-018 (Order R 85-3), § 284-30-700, filed 8/12/85.]

WAC 284-30-750 Insurance producers' and surplus line brokers' fees to be disclosed. It shall be an unfair practice for any insurance producer or surplus line broker providing services in connection with the procurement of insurance to charge a fee in excess of the usual commission which would be paid to an insurance producer or surplus line broker without having advised the insured or prospective insured, in writing, in advance of the rendering of services, that there will be a charge and its amount or the basis on which such charge will be determined.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.010(5). WSR 11-01-159 (Matter No. R 2010-09), § 284-30-750, filed 12/22/10, effective 1/22/11. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. WSR 87-09-071 (Order R 87-5), § 284-30-750, filed 4/21/87.]

WAC 284-30-770 Adverse notification requirements. (1) This section applies to all insurers, fraternal benefit societies, health carriers including disability, health maintenance organizations (HMOs), health care service contractors (HCSCs), and limited licensed carriers, and to all insurance policies, health plans, and insurance contracts.

(2) For the purpose of this section only the term "Adverse notification" means a notice, statement, or document from an insurer, fra-

ternal benefit societies, health carriers including disability, HMOs, HCSCs, and limited licensed carriers to their insured, or enrollee, or both, describing one or more of the following:

- (a) A claim denial;
 - (b) A final claim payment for less than the amount of the claim submitted. This does not include a claim that is paid less than the original amount to reflect the contracted health care provider's rate;
 - (c) An adverse benefit determination as defined in RCW 48.43.005(2); and
 - (d) Rescission, cancellation, termination or nonrenewal of a policy unless initiated by an insured. This does not apply to the end of a scheduled policy term or cancellation due to nonpayment of premium.
- (3) On each adverse notification provided, the notice must include the following information:

"If you have questions or concerns about the actions of your insurance company or agent, or would like information on your rights to file an appeal, contact the Washington state Office of the Insurance Commissioner's consumer protection hotline at 1-800-562-6900 or visit www.insurance.wa.gov. The insurance commissioner protects and educates insurance consumers, advances the public interest, and provides fair and efficient regulation of the insurance industry."

(4) The notice specified in subsection (3) of this section must be in the same font type and not less than the font size of the majority of the notification. This notice must appear on the first page, at the end of the adverse notification, or where this notice currently exists if adverse notices are already provided to insureds.

[Statutory Authority: RCW 48.02.060, 48.18.545, 48.19.035, 48.43.525, and 48.43.535. WSR 20-03-113 (Matter No. R 2019-09), § 284-30-770, filed 1/16/20, effective 8/1/20.]

MILITARY SALES PRACTICES

WAC 284-30-850 Authority, purpose, and effective date. In order to prevent unfair methods of insurance sales to active duty service members of the United States armed forces, unfair competition, and unfair or deceptive acts or practices by insurers, fraternal benefit societies, or insurance producers, WAC 284-30-850 through 284-30-872 are adopted. These rules may be called the "military sales practices" rules.

(1) The Military Personnel Financial Services Protection Act (P.L. 109-290) was enacted by the 109th Congress to protect members of the United States armed forces from unscrupulous practices regarding the sale of insurance, financial, and investment products on and off military installations. The act requires this state to adopt rules that meet sales practice standards adopted by the National Association of Insurance Commissioners to protect members of the United States armed forces from dishonest and predatory insurance sales practices both on and off of a military installation.

(2) Based on the commissioner's authority under RCW 48.30.010 to define by rule methods of competition and other acts and practices in the conduct of the business of insurance found by the commissioner to be unfair or deceptive, after evaluation of the acts and practices of insurers, fraternal benefit societies, or insurance producers that in-

formed the need for P.L. 109-290, and because the commissioner is required by that act to adopt rules that meet the sales practice standards adopted by the National Association of Insurance Commissioners and federal law, the commissioner finds the acts or practices set forth in WAC 284-30-850 through 284-30-872 to be unfair or deceptive methods of competition or unfair or deceptive acts or practices in the business of insurance.

(3) These military sales practices rules are effective for all benefit contracts, insurance policies and certificates solicited, issued, or delivered in this state on and after (the effective date of these rules).

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.010(5). WSR 11-01-159 (Matter No. R 2010-09), § 284-30-850, filed 12/22/10, effective 1/22/11. Statutory Authority: RCW 48.02.060 and 48.30.010. WSR 07-17-120 (Matter No. R 2007-01), § 284-30-850, filed 8/20/07, effective 9/20/07.]

WAC 284-30-855 Scope. WAC 284-30-850 through 284-30-872 affect all life insurance policies and certificates solicited or sold to an active duty service member of the United States armed forces or his or her dependent.

[Statutory Authority: RCW 48.02.060 and 48.30.010. WSR 07-17-120 (Matter No. R 2007-01), § 284-30-855, filed 8/20/07, effective 9/20/07.]

WAC 284-30-860 Exemptions. (1) The following life insurance solicitations or sales are exempt from the requirements of WAC 284-30-850 through 284-30-872:

(a) Credit life insurance.

(b) Group life insurance where there is no in-person face-to-face solicitation of individuals by a licensed insurance producer or where the policy or certificate does not include a side fund.

(c) An application to the insurer that issued the existing policy or certificate when a contractual change or a conversion privilege is being exercised; or when the existing insurance policy or certificate is being replaced by the same insurer pursuant to a program filed with and approved by the commissioner; or, when a term life conversion privilege is exercised among corporate affiliates.

(d) Individual, stand-alone policies of health or disability income insurance.

(e) Contracts offered by Servicemembers Group Life Insurance (SGLI) or Veterans Group Life Insurance (VGLI), as authorized by 38 U.S.C. section 1965 et seq., and contracts offered by State Sponsored Life Insurance (SSLI) as authorized by 37 U.S.C. Section 707 et seq.

(f) Life insurance policies or certificates offered through or by a nonprofit military association, qualifying under section 501(c)(23) of the Internal Revenue Code (IRC), and which are not underwritten by an insurer.

(g) Contracts used to fund any of the following:

(i) An employee pension or welfare benefit plan that is covered by the Employee Retirement and Income Security Act (ERISA);

(ii) A plan described by sections 401(a), 401(k), 403(b), 408(k), or 408(p) of the IRC, as amended, if established or maintained by an employer;

(iii) A government or church plan defined in section 414 of the IRC, a government or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax exempt organization under section 457 of the IRC;

(iv) A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor;

(v) Settlements of or assumptions of liabilities associated with personal injury litigation or any dispute or claim resolution process; or

(vi) Prearranged funeral contracts.

(2) Nothing in WAC 284-30-850 through 284-30-872 shall be construed to restrict the ability of nonprofit organizations or other organizations to educate members of the United States armed forces in accordance with federal Department of Defense Instruction 1344.07 "Personal Commercial Solicitation on DOD Installations," or any successor directive.

(3) (a) For purposes of the military sales practices rules, general advertisements, direct mail and internet marketing do not constitute "solicitation." Telephone marketing does not constitute "solicitation" only if the caller explicitly and conspicuously discloses that the product being solicited is life insurance and the caller makes no statements that avoid a clear and unequivocal statement that life insurance is the subject matter of the solicitation.

(b) Nothing in this section shall be construed to exempt an insurer, or insurance producer from the military sales practices rules in any in-person face-to-face meeting established as a result of the solicitation exemptions listed in this section.

[Statutory Authority: RCW 48.02.060 (3) (a) and 48.17.010(5). WSR 11-01-159 (Matter No. R 2010-09), § 284-30-860, filed 12/22/10, effective 1/22/11. Statutory Authority: RCW 48.02.060 and 48.30.010. WSR 07-17-120 (Matter No. R 2007-01), § 284-30-860, filed 8/20/07, effective 9/20/07.]

WAC 284-30-865 Definitions. The following definitions apply to the military sales practices rules, unless the context clearly requires otherwise:

(1) "Active duty" means full-time duty in the active military service of the United States and includes members of the reserve component, such as national guard or reserve, while serving under published orders for active duty or full-time training. This term does not include members of the reserve component who are performing active duty or active duty for training under military calls or orders specifying periods of fewer than thirty-one calendar days.

(2) "Department of Defense (DOD) personnel" means all active duty service members and all civilian employees, including nonappropriated fund employees and special government employees, of the Department of Defense.

(3) "Door-to-door" means a solicitation or sales method whereby an insurance producer proceeds randomly or selectively from household to household without a prior specific appointment.

(4) "General advertisement" means an advertisement having as its sole purpose the promotion of the reader's or viewer's interest in the concept of insurance or the promotion of an insurer or insurance producer.

(5) "Insurer" means an insurance company, as defined in RCW 48.01.050, that provides life insurance products for sale in this state. The term "insurer" also includes fraternal benefit societies, as defined at RCW 48.36A.010. Whenever the term "insurer," "policy," or "certificate" is used in these military sales practices rules, it includes insurers and fraternal benefit societies and applies to all insurance policies, benefit contracts, and certificates of life insurance issued by them.

(6) "Known" or "knowingly" means, depending on its use in WAC 284-30-870 and 284-30-872, that the insurer or insurance producer had actual awareness, or in the exercise of ordinary care should have known at the time of the act or practice complained of that the person being solicited is either:

(a) A service member; or

(b) A service member with a pay grade of E-4 or below.

(7) "Life insurance" has the meaning set forth in RCW 48.11.020.

(8) "Military installation" means any federally owned, leased, or operated base, reservation, post, camp, building, or other facility to which service members are assigned for duty, including barracks, transient housing, and family quarters.

(9) "MyPay" means the Defense Finance and Accounting Service (DFAS) web-based system that enables service members to process certain discretionary pay transactions or provide updates to personal information data elements without using paper forms.

(10) "Service member" means any active duty officer (commissioned and warrant) or any enlisted member of the United States armed forces.

(11) "Side fund" means a fund or reserve that is part of or is attached to a life insurance policy or certificate (except for individually issued annuities) by rider, endorsement, or other mechanism which accumulates premium or deposits with interest or by other means. The term does not include:

(a) Accumulated or cash value or secondary guarantees provided by a universal life policy;

(b) Cash values provided by a whole life policy which are subject to standard nonforfeiture law for life insurance; or

(c) A premium deposit fund which:

(i) Contains only premiums paid in advance which accumulate at interest;

(ii) Imposes no penalty for withdrawal;

(iii) Does not permit funding beyond future required premiums;

(iv) Is not marketed or intended as an investment; and

(v) Does not carry a commission, either paid or calculated.

(12) "Specific appointment" means a prearranged appointment that has been agreed upon by both parties and is definite as to place and time.

(13) "United States armed forces" means all components of the Army, Navy, Air Force, Marine Corps, and Coast Guard.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.010(5). WSR 11-01-159 (Matter No. R 2010-09), § 284-30-865, filed 12/22/10, effective 1/22/11. Statutory Authority: RCW 48.02.060 and 48.30.010. WSR 07-17-120 (Matter No. R 2007-01), § 284-30-865, filed 8/20/07, effective 9/20/07.]

WAC 284-30-870 Practices declared to be unfair or deceptive when committed on a military installation. (1) The following acts or prac-

tices by an insurer or insurance producer are found by the commissioner to be false, misleading, unfair or deceptive methods of competition or unfair or deceptive or acts or practices in the conduct of the business of insurance when committed on a military installation and solicited in-person face-to-face:

(a) Knowingly soliciting the purchase of any life insurance policy or certificate door to door or without first establishing a specific appointment for each meeting with the prospective purchaser.

(b) Soliciting service members in a group or mass audience or in a captive audience where attendance is not voluntary.

(c) Knowingly making appointments with or soliciting service members during their normally scheduled duty hours.

(d) Making appointments with or soliciting service members in barracks, day rooms, unit areas, or transient personnel housing, or other areas where the installation commander has prohibited solicitation.

(e) Soliciting the sale of life insurance without first obtaining permission from the installation commander or the commander's designee.

(f) Posting unauthorized bulletins, notices, or advertisements.

(g) Failing to present DD Form 2885 Personal Commercial Solicitation Evaluation, to service members solicited or encouraging service members solicited not to complete or submit a DD Form 2885.

(h) Knowingly accepting an application for life insurance or issuing a policy or certificate of life insurance on the life of an enlisted member of the United States armed forces without first obtaining for the insurer's files a completed copy of any required form which confirms that the applicant has received counseling or fulfilled any other similar requirement related to the sale of life insurance established by regulations, directives, or rules of the DOD or any branch of the United States armed forces.

(2) The following acts or practices by an insurer or insurance producer are found by the commissioner to be false, misleading, unfair or deceptive methods of competition or unfair or deceptive acts or practices in the conduct of the business of insurance or improper influences or inducements when committed on a military installation:

(a) Using DOD personnel, directly or indirectly, as a representative or agent in any official or business capacity with or without compensation with respect to the solicitation or sale of life insurance to service members.

(b) Using an insurance producer to participate in any education or orientation program sponsored by United States armed forces.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.010(5). WSR 11-01-159 (Matter No. R 2010-09), § 284-30-870, filed 12/22/10, effective 1/22/11. Statutory Authority: RCW 48.02.060 and 48.30.010. WSR 07-17-120 (Matter No. R 2007-01), § 284-30-870, filed 8/20/07, effective 9/20/07.]

WAC 284-30-872 Practices declared to be unfair or deceptive regardless of where they occur. (1) The following acts or practices by an insurer or insurance producer are found by the commissioner and declared to be false, misleading, unfair or deceptive methods of competition or unfair or deceptive or acts or practices in the conduct of the business of insurance or improper influences or inducements regardless of the location where they occur:

(a) Submitting, processing, or assisting in the submission or processing of any allotment form or similar device used by the United States armed forces to direct a service member's pay to a third party for the purchase of life insurance. For example, the using or assisting in the use of a service member's "MyPay" account or other similar internet or electronic medium to pay for life insurance is prohibited. For purposes of these military sales practices rules, assisting a service member by providing insurer or premium information necessary to complete any allotment form is not an unfair, deceptive, or prohibited practice.

(b) Knowingly receiving funds from a service member for the payment of premium from a depository institution with which the service member has no formal banking relationship. For purposes of this section, a formal banking relationship is established when the depository institution:

(i) Provides the service member a deposit agreement and periodic statements and makes the disclosures required by the Truth in Savings Act, 12 U.S.C. § 4301 et seq. and regulations promulgated thereunder; and

(ii) Permits the service member to make deposits and withdrawals unrelated to the payment or processing of insurance premiums.

(c) Employing any device or method, or entering into any agreement whereby funds received from a service member by allotment for the payment of insurance premiums are identified on the service member's leave and earnings statement (or equivalent or successor form) as "savings" or "checking" and where the service member has no formal banking relationship.

(d) Entering into any agreement with a depository institution for the purpose of receiving funds from a service member whereby the depository institution, with or without compensation, agrees to accept direct deposits from a service member with whom it has no formal banking relationship.

(e) Using DOD personnel, directly or indirectly, as a representative or agent in any official or unofficial capacity with or without compensation with respect to the solicitation or sale of life insurance to service members who are junior in rank or grade, or to their family members.

(f) Offering or giving anything of value, directly or indirectly, to DOD personnel to procure their assistance in encouraging, assisting, or facilitating the solicitation or sale of life insurance to another service member.

(g) Knowingly offering or giving anything of value to a service member with a pay grade of E-4 or below for his or her attendance to any event where an application for life insurance is solicited.

(h) Advising a service member with a pay grade of E-4 or below to change his or her income tax withholding or state of legal residence for the sole purpose of increasing disposable income in order to purchase life insurance.

(2) The following acts or practices by an insurer or insurance producer may lead to confusion regarding the source, sponsorship, approval, or affiliation of the insurer or any insurance producer. They are each found by the commissioner to be false, misleading, unfair or deceptive methods of competition or unfair or deceptive or acts or practices in the conduct of the business of insurance regardless of the location where they occur:

(a) Making any representation, or using any device, title, descriptive name, or identifier that has the tendency or capacity to

confuse or mislead a service member into believing that the insurer or insurance producer, or the policy or certificate offered is affiliated, connected, or associated with, endorsed, sponsored, sanctioned, or recommended by the U.S. government, the United States armed forces, or any state or federal agency or governmental entity.

(i) For example, the use of the following titles, including but not limited to the following is prohibited: Battalion insurance counselor, unit insurance advisor, Servicemen's Group Life Insurance conversion consultant, or veteran's benefits counselor.

(ii) A person is not prohibited from using a professional designation awarded after the successful completion of a course of instruction in the business of insurance by an accredited institution of higher learning. Examples include, but are not limited to the following: Chartered life underwriter (CLU), chartered financial consultant (ChFC), certified financial planner (CFP), master of science in financial services (MSFS), or masters of science financial planning (MS).

(b) Soliciting the purchase of any life insurance policy or certificate through the use of or in conjunction with any third-party organization that promotes the welfare of or assists members of the United States armed forces in a manner that has the tendency or capacity to confuse or mislead a service member into believing that the insurer or insurance producer, or the insurance policy or certificate is affiliated, connected, or associated with endorsed, sponsored, sanctioned, or recommended by the U.S. government, or the United States armed forces.

(3) The following acts or practices by an insurer or insurance producer lead to confusion regarding premiums, costs, or investment returns. They are each found by the commissioner to be false, misleading, unfair or deceptive methods of competition or unfair or deceptive or acts or practices in the conduct of the business of insurance regardless of the location where they occur:

(a) Using or describing the credited interest rate on a life insurance policy in a manner that implies that the credited interest rate is a net return on premium paid.

(b) Misrepresenting the mortality costs of a life insurance policy or certificate (except for individually issued annuities), including stating or implying that the policy or certificate costs nothing or is free.

(4) The following acts or practices by an insurer or insurance producer regarding Servicemembers Group Life Insurance (SGLI) or Veterans Group Life Insurance (VGLI) are each found by the commissioner to be false, misleading, unfair, or deceptive methods of competition or unfair or deceptive acts or practices in the conduct of the business of insurance regardless of the location where they occur:

(a) Making any representation regarding the availability, suitability, amount, cost, exclusions, or limitations to coverage provided to service members or dependents by SGLI or VGLI, which is false, misleading, or deceptive.

(b) Making any representation regarding conversion requirements, including the costs of coverage, exclusions, or limitations to coverage of SGLI or VGLI to private insurers which is false, misleading, or deceptive.

(c) Suggesting, recommending, or encouraging a service member to cancel or terminate his or her SGLI policy, or issuing a life insurance policy or certificate which replaces an existing SGLI policy unless the replacement takes effect upon or after separation of the service member from the United States armed forces.

(5) The following acts or practices regarding disclosure by an insurer or insurance producer are declared to be false, misleading, unfair, or deceptive methods of competition or unfair or deceptive acts or practices in the conduct of the business of insurance regardless of the location where the act occurs:

(a) Deploying, using, or contracting for any lead generating materials designed exclusively for use with service members that do not clearly and conspicuously disclose that the recipient will be contacted by an insurance producer, if that is the case, for the purpose of soliciting the purchase of life insurance.

(b) Failing to disclose that a solicitation for the sale of life insurance will be made when establishing a specific appointment for an in-person face-to-face meeting with a prospective purchaser.

(c) Except for individually issued annuities, failing to clearly and conspicuously disclose the fact that the policy or certificate being solicited is life insurance.

(d) Failing to make, at the time of sale or offer to an individual known to be a service member, the written disclosures required by Section 10 of the Military Personnel Financial Services Protection Act (P.L. 109-290), p. 16.

(e) Except for individually issued annuities, when the sale is conducted in-person face-to-face with an individual known to be a service member, failing to provide the applicant at the time of application is taken:

(i) An explanation of any free look period with instructions on how to cancel any policy or certificate issued by the insurer; and

(ii) Either a copy of the application or a written disclosure. The copy of the application or the written disclosure must clearly and concisely set out the type of life insurance, the death benefit applied for, and its expected first year cost. A basic illustration that meets the requirements of this state will be considered a written disclosure.

(6) The following acts or practices by an insurer or insurance producer are each found by the commissioner to be false, misleading, unfair or deceptive methods of competition or unfair or deceptive or acts or practices in the conduct of the business of insurance regardless of the location where they occur:

(a) Except for individually issued annuities, recommending the purchase of any life insurance policy or certificate which includes a side fund to a service member in pay grades E-4 and below unless the insurer has reasonable grounds for believing that the life insurance death benefit, standing alone, is suitable.

(b) Offering for sale or selling a life insurance policy or certificate which includes a side fund to a service member in pay grades E-4 and below who is currently enrolled in SGLI, is presumed unsuitable unless, after the completion of a needs assessment, the insurer demonstrates that the applicant's SGLI death benefit, together with any other military survivor benefits, savings and investments, survivor income, and other life insurance are insufficient to meet the applicant's insurable needs for life insurance.

(i) "Insurable needs" are the risks associated with premature death taking into consideration the financial obligations and immediate and future cash needs of the applicant's estate, survivors, or dependents.

(ii) Other military survivor's benefits include, but are not limited to: The death gratuity, funeral reimbursement, transition assistance, survivor and dependents' educational assistance, dependency

and indemnity compensation, TRICARE health care benefits, survivor housing benefits and allowances, federal income tax forgiveness, and Social Security survivor benefits.

(c) Except for individually issued annuities, offering for sale or selling any life insurance policy or certificate which includes a side fund:

(i) Unless interest credited accrues from the date of deposit to the date of withdrawal and permits withdrawals without limit or penalty;

(ii) Unless the applicant has been provided with a schedule of effective rates of return based upon cash flows of the combined policy or certificate. For this disclosure, the effective rate of return must consider all premiums and cash contributions made by the policyholder and all cash accumulations and cash surrender values available to the policyholder in addition to life insurance coverage. This schedule must be provided for at least each policy year from year one to year ten and for every fifth policy year thereafter, ending at age one hundred, policy maturity, or final expiration; and

(iii) Which by default diverts or transfers funds accumulated in the side fund to pay, reduce, or offset any premiums due.

(d) Except for individually issued annuities, offering for sale or selling any life insurance policy or certificate which after considering all policy benefits, including but not limited to endowment, return of premium, or persistency, does not comply with standard non-forfeiture law for life insurance.

(e) Selling any life insurance policy or certificate to a person known to be a service member that excludes coverage if the insured's death is related to war, declared or undeclared, or any act related to military service, except for accidental death coverage (for example, double indemnity) which may be excluded.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.010(5). WSR 11-01-159 (Matter No. R 2010-09), § 284-30-872, filed 12/22/10, effective 1/22/11. Statutory Authority: RCW 48.02.060 and 48.30.010. WSR 07-17-120 (Matter No. R 2007-01), § 284-30-872, filed 8/20/07, effective 9/20/07.]

ENVIRONMENTAL CLAIMS

WAC 284-30-900 Purpose. (1) There are many insurance coverage disputes involving Washington insureds who face potential liability for their roles at polluted sites in this state. State and federal mandates exist for cleaning up the environment in order to address the adverse effects of hazardous substances on human health and safety and the environment in general. It is in the public interest to reduce the costs incurred in connection with environmental claims and to expedite the resolution of such claims. The state of Washington has a substantial public interest in the timely, efficient, and appropriate resolution of environmental claims involving the liability of insureds at polluted sites in this state. This interest is based on practices favoring good faith and fair dealing in insurance matters and on the state's broader health and safety interest in a clean environment.

(2) Insureds and insurers alike face claims complicated by factual issues concerning events that occurred in the distant past. Many sites with environmental damage involve long-term operations with mul-

multiple owners; therefore, issues related to lost policies which may provide insurance coverage in the environmental claims context provide uniquely challenging problems of both lost evidence and witnesses.

(3) Cooperation between insureds and insurers in fairly and expeditiously resolving legitimate disputes and in reducing or eliminating nonmeritorious claims is in the public interest. Facilitating cooperation in resolving legitimate lost policy disputes in environmental claims will reduce unnecessary litigation, thereby freeing more resources for environmental cleanup. Insureds and insurers are encouraged to participate in a mediation program in order to achieve a mutually acceptable, expeditious resolution of environmental claims without resort to costly and lengthy litigation.

(4) This regulation is adopted to provide minimum standards for the conduct of insureds and insurers for presenting and resolving environmental claims with the goal of facilitating the fair, principled, and efficient resolution of environmental claims without resort to unnecessary, time-consuming, and expensive litigation.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.01.030, 48.05.280, 48.15.100 and 48.15.170. WSR 95-09-014 (Order R 94-30), § 284-30-900, filed 4/10/95, effective 5/11/95.]

WAC 284-30-905 Scope. (1) This regulation applies to actions taken by an insurer on or after July 1, 1995, with regard to environmental claims arising under a general liability insurance policy issued to a Washington resident and concerning sites located within this state. This regulation does not apply to environmental claims for which coverage is resolved by judgment, settlement, or payment before July 1, 1995.

(2) This regulation is not exclusive, and acts or omissions, whether or not specified in WAC 284-30-900 through 284-30-940, may also be violations of other sections of the insurance code or other regulations promulgated thereunder.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.01.030, 48.05.280, 48.15.100 and 48.15.170. WSR 95-09-014 (Order R 94-30), § 284-30-905, filed 4/10/95, effective 5/11/95.]

WAC 284-30-910 Definitions. As used in this regulation:

(1) "Environmental claim" means a claim for defense or indemnity submitted under a general liability insurance policy by an insured facing, or allegedly facing, potential liability for bodily injury or property damage to others arising from a discharge of pollutants into land, air, or water.

(2) "General liability insurance policy" means a contract of insurance that provides coverage for the legal obligations of an insured for bodily injury or property damage to others. It includes, for example, pollution insurance policies and comprehensive general liability insurance policies; it does not include insurance policies relating to motor vehicles, personal coverage such as homeowners, or specialty line liability coverage such as directors and officers insurance, errors and omissions insurance, or other similar policies.

(3) "Insured" means a Washington resident who is either the named insured or is acting on behalf of a Washington resident who is a named insured, and is presenting an environmental claim.

(4) "Lost policy" includes general liability insurance policies that are alleged by an insured to be lost.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.01.030, 48.05.280, 48.15.100 and 48.15.170. WSR 95-09-014 (Order R 94-30), § 284-30-910, filed 4/10/95, effective 5/11/95.]

WAC 284-30-920 Procedures for resolving lost policy disputes regarding environmental claims. The commissioner has found and hereby defines it to be an unfair act or practice or an unfair method of competition for an insurer to fail to investigate thoroughly and promptly all claims of lost policies. It is also an unfair practice or an unfair method of competition for an insurer to fail to provide all facts known or discovered during an investigation concerning the issuance and terms of a policy, including copies of documents establishing such facts, to an insured claiming coverage under a lost policy. A single violation of this section may be deemed by the commissioner to be an unfair act or practice or an unfair method of competition. The following procedures are minimum standards for the facilitation of reconstructing a lost policy and determining its terms. These procedures do not create a presumption of coverage for the loss once the contract is reconstructed.

(1) Within fifteen working days after receipt by the insurer of notice of a lost policy, an insurer shall commence an investigation into its records, including its computer records, to determine whether it issued the lost policy. If the insurer determines that it issued the policy in question, it shall promptly commence an investigation into the terms and conditions relevant to the environmental claim.

(a) For purposes of this section, "notice of a lost policy" means written notice of the lost policy in sufficient detail to identify the person or entity seeking coverage, including information concerning the name of the alleged policyholder, if known, together with material facts known to the insured concerning the lost policy.

(b) Insureds and insurers shall fully cooperate with each other in the investigation of lost policy issues.

(i) Each shall provide to the other facts known or discovered during an investigation, including the identity of any witnesses with knowledge of facts related to the issuance or existence of a lost policy.

(ii) Each shall provide the other with copies of documents establishing facts related to the lost policy.

(iii) Neither an insured nor an insurer shall be required to produce material subject to the attorney-client privilege or the work product doctrine, or confidential claims documents provided to the insurer by another policyholder.

(2) If the insurer discovers information tending to show the issuance of a policy applicable to the claim, the following procedures shall apply:

(a) If the insurer is able to determine the terms of the policy, upon request the insurer shall provide to an insured an accurate copy or reconstruction of the policy or the portions of the policy located.

(b) If after diligent investigation the insurer is not able to locate all or part of the policy or to determine the terms, conditions, or exclusions of the policy, the insurer shall provide copies of all insurance policy forms potentially applicable to the environmental claim issued by the insurer during the applicable policy peri-

od. The insurer shall state which of the potentially applicable forms, if any, is most likely to have been issued and why, or alternatively, shall state why it is unable to identify the forms after a good faith search. Providing copies of forms and meeting the standards of this section, is neither an admission by an insurer that a policy was issued or effective, nor, if a policy were issued, that it was necessarily in the form produced, unless the insurer so states.

(c) If it is concluded that a general liability insurance policy more likely than not was issued to the insured by the insurer, and neither the insured nor the insurer can produce any evidence which may tend to show the policy limits applicable to the policy, it shall be assumed, in the absence of other evidence, that the minimum limits of coverage offered by the insurer during the period in question were purchased by the insured.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.01.030, 48.05.280, 48.15.100 and 48.15.170. WSR 95-09-014 (Order R 94-30), § 284-30-920, filed 4/10/95, effective 5/11/95.]

WAC 284-30-930 Specific unfair environmental claims settlement or trade practices defined. The commissioner has found and hereby defines the following acts or practices related to the settlement of environmental claims to be unfair methods of competition or unfair or deceptive acts or practices in the conduct of the business of insurance. A single violation of this section may be deemed by the commissioner to be an unfair claims settlement practice, an unfair trade practice, or an unfair method of competition.

(1) Failure to pay interest at the statutory rate as set by the state treasurer from time to time, pursuant to RCW 19.52.025:

(a) On payments that an insured has made and which the insurer is legally obligated to pay as damages: Provided however, That interest shall begin to accrue only when a claim is presented or payment is made by the insured, whichever is the later; or

(b) On overdue payments that an insurer agreed to make pursuant to an agreed settlement with an insured: Provided however, That interest shall begin to accrue on the thirty-first day after the date of the settlement or the agreed time, if later.

(2) Failure of an insurer to commence investigation of an environmental claim within fifteen working days after receipt of a notice of an environmental claim.

(a) Insureds and insurers shall fully cooperate with each other in the investigation of environmental claims.

(i) Each shall provide to the other facts known or discovered during an investigation, including the identity of any witnesses with knowledge of facts related to an environmental claim.

(ii) Each shall provide the other with copies of documents establishing facts related to an environmental claim.

(iii) Neither an insured nor an insurer shall be required to produce material subject to the attorney-client privilege or the work product doctrine, or confidential claims documents provided to the insurer by another policyholder.

(b) An excess insurer may rely on the investigation of a primary insurer.

(3) Failure to make payments, under its duty to defend, for costs reasonably incurred in an investigation to determine the source of

contamination, the type of contamination, and the extent of the contamination.

(4) Denying a claim on the basis that the insured expected or intended the damage unless, to the best of the insurer's knowledge, information, and belief, formed after reasonable inquiry, the insurer's position is well grounded in fact and is warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law, and that it is not interposed for any improper purpose, such as to harass or to cause unnecessary delay or needless increase in the cost of litigation.

(5) Denying that there is damage to a site that is listed on the National Priorities List under the Comprehensive Environmental Response Compensation and Liabilities Act of 1980, 42 U.S.C. Sections 6901-6992k, or the hazardous sites list under the Model Toxics Control Act of Washington, chapter 70.105D RCW, if the federal Environmental Protection Agency or the state department of ecology has determined that there is actual damage on the site unless an insurer has evidence that no actual damage occurred. It should not be presumed that only sites on the National Priorities List or the hazardous sites list have environmental damage requiring action.

(6) Requiring the insured to provide answers to repetitive questions and requests for information concerning matters or issues unrelated to the insured's environmental claim. This does not prevent an insurer from clearly reserving its rights as to information that is not available at the time of the correspondence.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.01.030, 48.05.280, 48.15.100 and 48.15.170. WSR 95-09-014 (Order R 94-30), § 284-30-930, filed 4/10/95, effective 5/11/95.]

WAC 284-30-940 Environmental claim mediation program. The commissioner has found and hereby defines it to be an unfair act or practice or an unfair method of competition for an insurer to fail to participate in good faith in nonbinding mediation requested by an insured concerning the existence, terms, or conditions of a lost policy, or regarding coverage for an environmental claim.

(1) The insured may request in writing that the insurer participate in nonbinding mediation.

(2) Upon request from an insured for nonbinding mediation, an insurer shall provide an insured with information concerning an environmental claim mediation program. The information shall include, but need not be limited to, a description of how an insured can efficiently commence a mediation program.

(3) The purposes of mediation shall include, but need not be limited to, the following:

(a) To assist the parties in resolving disputes concerning whether or not a general liability insurance policy applicable to the environmental claim was issued to the insured by the insurer or concerning the relevant terms, conditions, and exclusions of the policy;

(b) To determine whether the entire claim, or a portion thereof, can be settled by agreement of the parties;

(c) If the claim cannot be settled, to determine whether one or more issues can be resolved to the satisfaction of the parties; or

(d) To discuss any other methods of streamlining or reducing the cost of litigation.

(4) Mediation shall be conducted pursuant to mediation rules similar to those of the American Arbitration Association, the Center for Public Resources, the Judicial Arbitration and Mediation Service, RCW 7.70.100, or any other rules of mediation agreed to by the parties.

(5) Unless otherwise agreed, information provided and statements made by either party in a mediation shall be kept confidential by the parties and used only for purposes of the mediation in accordance with RCW 5.60.070.

(6) Insureds and insurers shall have representatives present, or available by telephone, with authority to settle the matter at all mediation sessions.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.01.030, 48.05.280, 48.15.100 and 48.15.170. WSR 95-09-014 (Order R 94-30), § 284-30-940, filed 4/10/95, effective 5/11/95.]