WSR 26-17-089
PERMANENT RULES
OFFICE OF THE
INSURANCE COMMISSIONER

[Insurance Commissioner Matter R 2025-05—Filed August 18, 2026, 9:15 a.m., effective October 18, 2026]

Effective Date of Rule: October 18, 2026.

Purpose: The office of the insurance commissioner (commissioner) is adopting rules to define unfair trade practices and to help clarify the minimum standards for claims handling in Washington state. The rule allows the insurance industry and Washington state consumers a more fair and transparent claim process. The rule clarifies and adds definitions and specific unfair claim practices concerning claims handling, particularly when the insurer is considering coverage determinations, and if coverage is available, the loss and damage valuation that is owed under the policy. The rule adds additional requirements for the insurer to provide detailed information to the claimant at certain points in the claim process.

The anticipated effects of the rule are that claimants have more transparency into their financial recovery, insureds have better access to the benefits of the insurance policy they have purchased, insurers appropriately investigate claims and make timely and accurate payments, and insurers and claimants have additional clarity on the minimum standards of claims handling activities that increasingly rely on technology for evaluation of claims.

While the state's total number of automobile and homeowners' insurance claims have remained consistent over the past six years, the commissioner has received an increase in consumer complaints and Insurance Fair Conduct Act notices, which indicate a consumer's dissatisfaction with the claims handling process and the intent to sue their insurer. The spike in consumer complaints and lawsuits against insurers indicate potential insurance code violations, and an increase in the use of practices that are unfair or deceptive in the context of processing claims.

The commissioner held a claims process public meeting in 2023 where consumers shared dozens of comments and hours of testimony outlining their difficulties with insurance claims. The commissioner also has received studies and reports from local and national observers of the claim environment detailing delays and inaccuracies from the insurance company that harm consumers. Furthermore, the commissioner has received articles, reports, and studies from insurance experts that the insurance industry is changing their claim process from an in-person, on-site, loss examination to the use of artificial intelligence and photo-based loss adjusting to maximize efficiencies.

A contract of insurance is a promise to provide the benefits of the policy when there is a covered event. When an insurer fails to properly investigate a claim to make timely and accurate payments, it either causes the claimant to have do their own investigation or receive less than what is owed under the policy. Either way, the insured does not receive the full benefit of the policy they have purchased. Claim process disputes can occur when the insurance company fails to fairly and fully investigate the loss, properly communicate to the claimant, or at times force the insured to complete the insurance company's investigative duties. With a changing technological and workforce environment, the proposed rule making will update and clarify requirements to maintain a fair claim environment for consumers and

provide transparency into the decisions that affect their financial recovery.

Citation of Rules Affected by this Order: Amending WAC 284-30-300, 284-30-320, 284-30-330, 284-30-340, 284-30-350, 284-30-355, 284-30-360, 284-30-370, 284-30-380, 284-30-390, 284-30-391, 284-30-392, 284-30-393, 284-30-394, and 284-30-395.

Statutory Authority for Adoption: RCW 48.02.060 and 48.30.010.

Adopted under notice filed as WSR 26-10-078 on May 5, 2026.

Changes Other than Editing from Proposed to Adopted Version: The commissioner removed the new definition of "undisputed amounts" in WAC 284-30-320 and the corresponding new subsection in WAC 284-30-330 relating to unfair claim practice. After multiple preproposal public drafts, these two subsections were first introduced in the initial CR-102 and comment was provided. The supplemental CR-102 included an exception for underinsured motorist and uninsured motorist bodily injury claims and comment was provided. By removing these two subsections, the commissioner is returning the rule language on this topic back to what it was before rule making began, and after providing for public comment in multiple preproposal rule drafts, the commissioner is no longer proposing edits to the rule on this topic.

After comments on potential inconsistencies and confusion, the commissioner removed "for property and vehicle damage" in WAC 284-30-380(7) when describing the insurer's nondelegable duty that they are responsible for the accuracy of their evaluations to determine amounts owed under the applicable insurance policy. The removal of this language is to prevent confusion and irregularities when applying the definition of "investigation" in WAC 284-30-320 and applicability of WAC 284-30-330(4) on the unfair practice of denying or refusing to pay claims in part or in full without conducting a reasonable investigation.

The commissioner simplified and matched language in WAC 284-30-392 (4)(d) and (e) to reflect the similar requirements on insurers to provide to the claimant the supporting photographs and documentation to demonstrate the condition of the comparable, or loss, vehicle when it reduces the value of the claim due to condition of either vehicle.

A final cost-benefit analysis is available by contacting Rules Coordinator, P.O. Box 40255, Olympia, WA 98504-7038, phone 360-725-7171, fax 360-586-3109, email rulescoordinator@oic.wa.gov.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 15, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 15, Repealed 0.

Date Adopted: August 18, 2026.

Patty Kuderer
Insurance Commissioner

RDS-7031.7

AMENDATORY SECTION (Amending WSR 09-11-129, filed 5/20/09, effective 8/21/09)

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.

If any provision of this chapter, or the application of such provision of this chapter to any person or circumstances, shall be held invalid, the invalidity does not affect other provisions which can be given effect without the invalid provision or application, and to this end the provisions of these sections are severable.

AMENDATORY SECTION (Amending WSR 20-24-070, filed 11/24/20, effective 12/25/20)

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~~)) 90 calendar 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~~)) 51 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. An investigation includes, but is not limited to, conducting a reasonable assessment of whether each claim or loss is covered under the policy, the scope and value of loss or damage caused by an event, and the reasonableness of the costs or expenses that have been or will be incurred to mitigate, treat, repair, replace, or recover the covered loss or damage.

(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.

AMENDATORY SECTION (Amending WSR 16-20-050, filed 9/29/16, effective 10/30/16)

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) Denying or refusing to pay claims in part or in full without conducting a reasonable investigation. A reasonable investigation may not rely solely on the use of a database, which includes, but is not limited to, estimating software and benchmarks gathered from one or multiple databases.

(5) Failing to affirm or deny coverage of claims within a reasonable time after ((~~fully completed proof of loss documentation has been submitted~~)) receiving a notification of claim.

(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 a claim((~~s~~)) by requiring either a ((~~first party~~)) claimant ((~~or~~)), his or her ((~~physician~~)) service or medical provider, or both, to submit ((~~a preliminary claim report~~)) documents or information 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~~)) treating a claimant differently because they are represented by a public adjuster. This includes, but is not limited to, failure to recognize a public adjuster as the legal representative of the insured, or failure to timely provide the requested pertinent claim information and insurance policy to either the insured, the public adjuster, or both.

(15) Failing to expeditiously honor drafts given in settlement of claims. A failure to honor a draft within three ((~~working~~)) business 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~~)) 15 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~~)) 20 business 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.

(20) Failing to approve the first party claimant's scope of mitigation or to provide the first party claimant with an approved scope of mitigation within five business days after receipt of the scope of mitigation from the first party claimant when there is a duty in the policy for the first party claimant to protect the property from further damage after a loss event.

(21) Failing to disclose the reasons why the first party claimant's scope of mitigation does not meet either technical or industry standards, including a dollar amount itemization of the disapproved items, if the insurer rejects the first party claimant's scope of mitigation.

(22) Requiring an appraiser functioning under the appraisal clause in the policy to adjust either their actual cash value, their valuation of loss, or both, at any time during the appraisal process. This does not prohibit the insurer from applying the policy conditions to a completed appraisal award.

(23) Providing inaccurate information to a nationwide specialty consumer reporting agency. For the purposes of this subsection, "nationwide specialty consumer reporting agency" has the same meaning as

defined in the federal Fair Credit Reporting Act, 15 U.S.C. Sec. 1681 (2023).

AMENDATORY SECTION (Amending WSR 09-11-129, filed 5/20/09, effective 8/21/09)

WAC 284-30-340 File and record documentation. A violation of any of the following is hereby defined as an unfair method of competition and an unfair or deceptive act or practice of the insurer in the business of insurance, specifically applicable to the documentation of claims:

(1) 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.

(2) Insureds shall have the right from time to time and at reasonable intervals to request and receive from their insurance company any portion of the first party claim file including, but not limited to, all written reports, claim notes, estimates, bids, plans, measurements, drawings, engineer reports, contractor reports, statements, photographs, video recordings, or any other documents or communications. If any portion of the claim file contains a record that the insurance company prepared or used during its adjustment of the policyholder's claim is either legally privileged, contains third-party financial information, or is a specific investigative record where the nondisclosure of which is essential to reasonable investigation of alleged criminal activity, the insurer may redact such information from the record or withhold the record if the entirety of the document would otherwise be redacted. The insurer has 15 business days from receipt of the request to provide all of the appropriate requested claim documents to the insured. If the insurer determines an insured's request under this subsection is unreasonable, the insurer must provide written notice to the insured explaining all of the reasons for its determination.

The insurer must indicate to the insured, at the time the first party claim file is provided, whether any documents were withheld or redacted because the documents are either legally privileged, contain third-party financial information, or are a specific investigative record where the nondisclosure of which is essential to a reasonable investigation of alleged criminal activity.

AMENDATORY SECTION (Amending WSR 11-01-159, filed 12/22/10, effective 1/22/11)

WAC 284-30-350 Misrepresentation of policy provisions. A violation of any of the following is hereby defined as an unfair method of competition and an unfair or deceptive act or practice of the insurer in the business of insurance, specifically applicable to the representation of policy provisions during the investigation and settlement of claims:

(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.

AMENDATORY SECTION (Amending WSR 12-09-052, filed 4/16/12, effective 5/17/12)

WAC 284-30-355 Certificates of insurance. A violation of any of the following is hereby defined as an unfair method of competition and an unfair or deceptive act or practice of the insurer in the business of insurance, specific to communications with certificate holders:

(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.

AMENDATORY SECTION (Amending WSR 13-12-079, filed 6/5/13, effective 1/1/14)

WAC 284-30-360 Standards for the insurer to acknowledge pertinent communications. A violation of any of the following is hereby defined as an unfair method of competition and an unfair or deceptive act or practice of the insurer in the business of insurance, specifically applicable to the communications concerning claims:

(1) Within ((~~ten working~~)) 10 business days after receiving a notification of ((~~a~~)) claim under an individual insurance policy, or within ((~~fifteen working~~)) 15 business 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 of claim given to an agent of the insurer is notification of claim 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~~)) 10 business 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~~)) 10 business days for individual insurance policies, or ((~~fifteen working~~)) 15 business days with respect to communications arising under group insurance contracts.

(4) Upon receiving a 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.

AMENDATORY SECTION (Amending WSR 09-11-129, filed 5/20/09, effective 8/21/09)

WAC 284-30-370 Standards for prompt investigation of a claim. A violation of any of the following is hereby defined as an unfair method of competition and an unfair or deceptive act or practice of the insurer in the business of insurance, specifically applicable to the investigation of claims:

(1) Every insurer must complete its investigation of a claim within ((~~thirty~~)) 30 calendar days after a 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.

(a) If the insurer needs more time to investigate the claim, it must notify the claimant in writing of the reasons it cannot complete the investigation of the claim within 30 calendar days from the notification of claim.

(b) If needed, additional written notice must be provided to the claimant every 30 days after the notice required in (a) of this subsection explaining why the investigation of the claim remains unresolved.

For the purposes of this subsection, the additional notice must include a summary of any decisions or actions that are substantially related to the disposition of a claim including, but not limited to:

(i) The amount of loss;

(ii) The retention or consultation of service and medical providers;

(iii) Each pertinent item the insurer is waiting for to complete its investigation of the claim; and

(iv) If a new adjuster has been assigned since last notice, confirmation that the new adjuster has reviewed the claim file and is prepared to timely continue the investigation.

(2) This section does not apply to medical professional liability claims.

AMENDATORY SECTION (Amending WSR 09-11-129, filed 5/20/09, effective 8/21/09)

WAC 284-30-380 Settlement standards applicable to all insurers. A violation of any of the following is hereby defined as an unfair method of competition and an unfair or deceptive act or practice of the insurer in the business of insurance, specifically applicable to the settlement of claims:

(1) Within ((~~fifteen working~~)) 30 calendar days after receipt by the insurer of ((~~fully completed and executed proofs of loss~~)) a notification of claim, the insurer must notify the first party claimant whether the claim has been accepted or denied. This timeline does not apply to medical professional liability claims. 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) of this section 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~~)) 30 calendar days after ((~~receipt of the proofs of loss giving~~)) a notification of claim and give all of 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~~)) all of the 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~~)) 30 calendar days after that date explaining why the claim remains unresolved. This subsection does not apply to medical professional liability claims.

(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~~)) 30 calendar days and to third-party claimants ((~~sixty~~)) 60 calendar 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 their evaluations including, but not limited to, evaluations made on their behalf, to determine ((~~actual cash value~~)) the amounts owed under the applicable insurance policy.

(8) If an insurer uses a database, survey, estimating software, or benchmarks to account for either material pricing, labor rate, or both, and upon request of the claimant, the insurer must provide the claimant with the date the data was collected, where the data was collected from, and which businesses provided the cost data to the database, survey, estimating software, or benchmarks.

AMENDATORY SECTION (Amending WSR 09-11-129, filed 5/20/09, effective 8/21/09)

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 inspect the damaged vehicle and reasonably communicate with the claimant and the repair facility chosen by the claimant on the damage and needed repairs.

(a) Motor vehicle inspection standards for this section include, but are not limited to:

(i) Insurers shall not require the claimant to agree to only photo-based evaluation of damage as a condition of coverage.

(ii) If an insurer is unable to document damages in a submitted photograph by the claimant, the claimant's chosen repair facility, or both, the insurer must make reasonable efforts to request additional documentation prior to rejecting the coverage of the submitted damage.

(iii) When a claimant has utilized the virtual inspection process and there is a disagreement on the amount of loss, the insurer must accept the claimant's request for an in-person inspection and conduct the inspection of the vehicle within five business days or another agreed time between claimant and insurer.

(iv) The insurer is responsible for the documentation that supports how their estimate to repair the damaged vehicle meets policy language.

(b) Communication standards for this section include, but are not limited to:

(i) Upon notification of claim the insurer must disclose to the claimant the ability to request an in-person inspection of the vehicle from the insurer's adjuster or chosen repair expert.

(ii) Insurers must document in writing to the claimant any repair costs in their submitted estimate for repair not covered under the policy and cite relevant policy language.

If requested by the claimant, the insurer must provide in writing how the labor and material costs and repair processes were determined and cite relevant policy language.

(iii) Insurers must respond in writing to the claimant and claimant's repair facility with its determination of amounts covered within five business days of insurer's receipt of any supplemental damage estimates and final invoice. If the insurer rejects any damage within the supplemental damage estimate and final invoice, the insurer must either cite the applicable policy language, explain the insurer's position in relation to the facts of the loss, or both.

(iv) Insurers must not require any claimant or the claimant's repair facility to solely use an internet-based application as the platform to provide claim related information. Insurers must allow the claimant and claimant's repair facility to use electronic mail, postal mail, facsimile, or delivery in person to submit claims related information.

(v) When requested by the claimant, insurers must include the claimant in all communications with the claimant's repair facility relating to either the original or supplemental repair estimates or changes to covered items.

(vi) Insurers must provide a first party claimant with a clear written explanation of how applicable storage and towing fees are covered under the policy within five business days of the notification of claim.

(2) ((~~Arbitrarily~~)) Unreasonably 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 promptly and fully disclose ((~~the reason or~~)) all of the reasons it paid less than the claimant's estimate, including a reasonable explanation of the cited policy provision to reject the claimant's repair estimate or invoice, 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 repair estimate, it must rely upon a competent person and provide a copy of the estimate to the claimant. "Competent" in this subsection means the person has the subject matter expertise, relevant training, and experience to make valuations and decisions relating to the repair process. An employee of the insurer may be considered competent if they meet the definition. The insurer is responsible for the accuracy of their repair documentation.

(b) If a claimant provides the repair 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~~)) all of the reasons for the difference to the claimant. This includes a reasonable explanation of cited policy provision to reject the claimant's repair estimate or invoice, 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 claimant, or the claimant's repair facility discover((s)) after assessing the damage or 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.

AMENDATORY SECTION (Amending WSR 09-11-129, filed 5/20/09, effective 8/21/09)

WAC 284-30-391 Methods and standards of practice for settlement of total loss vehicle claims. A violation of any of the following is hereby defined as an unfair method of competition and an unfair or deceptive act or practice of the insurer in the business of insurance, specifically applicable to the settlement of motor 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~~)) within a reasonable distance of the principally garaged area not to exceed 150 miles.

(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~~)) 150 miles (except where there are no licensed dealers having comparable motor vehicles within ((~~one hundred fifty~~)) 150 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~~)) 150 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~~)) 85 percent of all makes and models for a minimum of ((~~fifteen~~)) 15 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~~)) 150 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~~)) 90 calendar 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~~)) 30 comparable motor vehicles are located, the insurer need list only ((~~thirty~~)) 30 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~~)) 25 mile increments, up to ((~~one hundred and fifty~~)) 150 miles, until two or more comparable motor vehicles are located. If no comparable motor vehicles can be located within ((~~one hundred fifty~~)) 150 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.

The insurer must advise their appraiser of the total loss calculations in this section, and when applying an appraisal award to the policy, the insurer shall not consider any valuation that is not compliant with this section.

(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~~)) 90 calendar 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~~)) 30 calendar 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~~)) 35 calendar 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.

(7) If there is an agreed amount of loss and the first party claimant has rental coverage available, the insurer shall not limit the ability to use rental coverage for the lesser of seven calendar days after payment is sent to the claimant or until the rental coverage has been exhausted.

AMENDATORY SECTION (Amending WSR 09-11-129, 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. A violation of any of the following is hereby defined as an unfair method of competition and an unfair or deceptive act or practice of the insurer in the business of insurance, specifically applicable to motor vehicle claims:

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~~)) 30 comparable motor vehicles are used, only ((~~thirty~~)) 30 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.

(d) Upon request from the claimant, and if the insurer used condition of a comparable motor vehicle to reduce a payment to the claimant, then the insurer must provide to the claimant supporting photographs and documentation to demonstrate its determination of the condition.

(e) If the insurer makes a deduction of value of the loss vehicle's condition, it must provide to the claimant supporting photographs and documentation to demonstrate its determination of the condition.

AMENDATORY SECTION (Amending WSR 11-13-029, filed 6/7/11, effective 7/8/11)

WAC 284-30-393 Insurer must include an insured's deductible in its subrogation demands. A violation of any of the following is hereby defined as an unfair method of competition and an unfair or deceptive act or practice of the insurer in the business of insurance, specifically applicable to the settlement of motor vehicle claims:

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~~)) 60 calendar days after the start of the subrogation process, and no less frequently than every ((~~one hundred eighty~~)) 180 days until the insured's interest is resolved.

AMENDATORY SECTION (Amending WSR 09-11-129, filed 5/20/09, effective 8/21/09)

WAC 284-30-394 Denial of storage and towing costs. A violation of any of the following is hereby defined as an unfair method of competition and an unfair or deceptive act or practice of the insurer in the business of insurance, specifically applicable to the settlement of motor vehicle claims:

Prior to denying storage ((~~and~~)) or 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; and

(3) Pay any and all reasonable towing charges unless otherwise provided in the applicable insurance policy.

AMENDATORY SECTION (Amending WSR 12-19-081, filed 9/18/12, effective 4/1/13)

WAC 284-30-395 Standards for prompt, fair and equitable settlements applicable to automobile personal injury protection insurance. A violation of any of the following is hereby defined as an unfair method of competition and an unfair or deceptive act or practice of the insurer in the business of insurance, specifically applicable to the settlement of personal injury protection claims:

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 in-

clude 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 licensed, 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.