Product Liability – Property Damage – Tort Defense

50 State Survey

50 STATE CLAIMS HANDLING GUIDELINES

A collection of relevant claims handling guidelines gathered from statutes, codes, and administrative rulings from all 50 states.

Last Updated: June 2007

Note: This document is intended to provide a general overview of the laws enacted in each state. The statutes listed are complex and do not necessarily lend themselves to a concise summary. And, while we have made every effort to verify the accuracy of the materials summarized as of the date indicated, these statutes are subject to revision, amendment and modification as well as differing court interpretations. Therefore, it is intended that this document serve only as a guideline and general reference. It is not a substitute for legal advice from a qualified attorney.

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<table>
<thead>
<tr>
<th>State</th>
<th>Time Period in Which Insurer Must Acknowledge Claim</th>
<th>Time Period in Which Insurer Must Report Investigation of Claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Alaska</td>
<td>10 working days</td>
<td>15 working days after receipt of proof of loss and every 45 working days thereafter</td>
</tr>
<tr>
<td>Arizona</td>
<td>10 working days</td>
<td>15 working days after receipt of proof of loss and every 45 working days thereafter</td>
</tr>
<tr>
<td>Arkansas</td>
<td>15 working days</td>
<td>15 working days after receipt of proof of loss and every 45 calendar days thereafter</td>
</tr>
<tr>
<td>California</td>
<td>15 calendar days</td>
<td>40 calendar days after receipt of proof of loss and every 30 calendar days thereafter</td>
</tr>
<tr>
<td>Colorado</td>
<td>Promptly</td>
<td>Reasonable time</td>
</tr>
<tr>
<td>Connecticut</td>
<td>Promptly</td>
<td>Reasonable time</td>
</tr>
<tr>
<td>Delaware</td>
<td>15 working days</td>
<td>30 calendar days after receipt of proof of loss</td>
</tr>
<tr>
<td>Florida</td>
<td>14 calendar days</td>
<td>10 days must begin investigation only, no duty to report</td>
</tr>
<tr>
<td>Georgia</td>
<td>15 calendar days</td>
<td>15 calendar days after receipt of proof of loss, if no proof of loss required then 30 days, in any even no more than 60 days total</td>
</tr>
<tr>
<td>Hawaii</td>
<td>15 working days</td>
<td>30 calendar days after claim was reported</td>
</tr>
<tr>
<td>Idaho</td>
<td>Promptly</td>
<td>Reasonable time</td>
</tr>
<tr>
<td>Illinois</td>
<td>15 working days</td>
<td>within a reasonable time; shall offer payment within 30 days of affirmation of liability</td>
</tr>
<tr>
<td>Indiana</td>
<td>Promptly</td>
<td>Reasonable time</td>
</tr>
<tr>
<td>Iowa</td>
<td>Promptly</td>
<td>Reasonable time</td>
</tr>
<tr>
<td>Kansas</td>
<td>Promptly</td>
<td>Reasonable time</td>
</tr>
<tr>
<td>Kentucky</td>
<td>15 calendar days</td>
<td>30 calendar days after receipt of proof of loss and every 45 days thereafter</td>
</tr>
<tr>
<td>State</td>
<td>Time Period in Which Insurer Must Acknowledge Claim</td>
<td>Time Period in Which Insurer Must Report Investigation of Claim</td>
</tr>
<tr>
<td>------------------</td>
<td>-----------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>LOUISIANA</td>
<td>Promptly</td>
<td>Reasonable time</td>
</tr>
<tr>
<td>MAINE</td>
<td>Promptly</td>
<td>Reasonable time</td>
</tr>
<tr>
<td>MARYLAND</td>
<td>15 working days</td>
<td>15 working days after receipt of proof of loss and every 45 days thereafter</td>
</tr>
<tr>
<td>MASSACHUSETTS</td>
<td>Promptly</td>
<td>Reasonable time</td>
</tr>
<tr>
<td>MICHIGAN</td>
<td>30 calendar days</td>
<td>Reasonable time</td>
</tr>
<tr>
<td>MINNESOTA</td>
<td>10 business days</td>
<td>30 business days after receipt of notification of claim, and no more than 60 business days total</td>
</tr>
<tr>
<td>MISSISSIPPI</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>MISSOURI</td>
<td>10 working days</td>
<td>15 working days after receipt of proof of loss and every 45 days thereafter</td>
</tr>
<tr>
<td>MONTANA</td>
<td>Promptly</td>
<td>Reasonable time</td>
</tr>
<tr>
<td>NEBRASKA</td>
<td>Promptly</td>
<td>Reasonable time</td>
</tr>
<tr>
<td>NEVADA</td>
<td>20 working days</td>
<td>30 working days after receipt of proof of loss and every 30 days thereafter</td>
</tr>
<tr>
<td>NEW HAMPSHIRE</td>
<td>10 working days</td>
<td>10 working days after receipt of proof of loss and every 30 days thereafter</td>
</tr>
<tr>
<td>NEW JERSEY</td>
<td>10 working days</td>
<td>30 calendar days after receipt of proof of loss and every 45 days thereafter</td>
</tr>
<tr>
<td>NEW MEXICO</td>
<td>Promptly</td>
<td>Reasonable time period</td>
</tr>
<tr>
<td>NEW YORK</td>
<td>15 business days</td>
<td>15 business days after receipt of proof of loss and every 90 days thereafter</td>
</tr>
<tr>
<td>NORTH CAROLINA</td>
<td>30 calendar days</td>
<td>Reasonable time period</td>
</tr>
<tr>
<td>NORTH DAKOTA</td>
<td>Promptly, Reasonably</td>
<td>Promptly, Reasonably</td>
</tr>
<tr>
<td>OHIO</td>
<td>10 calendar days</td>
<td>21 calendar days after receipt of proof of loss and every 45 days thereafter</td>
</tr>
<tr>
<td>OKLAHOMA</td>
<td>20 business days</td>
<td>45 business days after receipt of proof of loss and every 45 days thereafter</td>
</tr>
<tr>
<td>OREGON</td>
<td>30 calendar days</td>
<td>30 calendar days after receipt of proof of loss and every 45 days thereafter</td>
</tr>
<tr>
<td>PENNSYLVANIA</td>
<td>10 working days</td>
<td>15 working days after receipt of proof of proof</td>
</tr>
</tbody>
</table>

**CLAIMS HANDLING GUIDELINES**
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<table>
<thead>
<tr>
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<th>Time Period in Which Insurer Must Acknowledge Claim</th>
<th>Time Period in Which Insurer Must Report Investigation of Claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>RHODE ISLAND</td>
<td>30 calendar days</td>
<td>Promptly</td>
</tr>
<tr>
<td>SOUTH CAROLINA</td>
<td>Promptly; if insurer requires written proof of loss, forms must be furnished within 20 days</td>
<td>Promptly</td>
</tr>
<tr>
<td>SOUTH DAKOTA</td>
<td>30 calendar days</td>
<td>Promptly</td>
</tr>
<tr>
<td>TENNESSEE</td>
<td>Promptly</td>
<td>Reasonable time period</td>
</tr>
<tr>
<td>TEXAS</td>
<td>15 business days</td>
<td>Promptly, within a reasonable time</td>
</tr>
<tr>
<td>UTAH</td>
<td>15 calendar days</td>
<td>30 calendar days after receipt of proof of loss and every 45 days thereafter</td>
</tr>
<tr>
<td>VERMONT</td>
<td>10 working days</td>
<td>15 working days after receipt of proof of loss and every 30 days thereafter</td>
</tr>
<tr>
<td>VIRGINIA</td>
<td>10 working days</td>
<td>15 working days after receipt of proof of loss and every 45 days thereafter</td>
</tr>
<tr>
<td>WASHINGTON</td>
<td>10 working days</td>
<td>15 working days after receipt of proof of loss and every 30 days thereafter</td>
</tr>
<tr>
<td>WEST VIRGINIA</td>
<td>15 working days</td>
<td>15 working days after expiration of 30 calendar days after receipt of proof of loss and every 45 calendar days thereafter</td>
</tr>
<tr>
<td>WISCONSIN</td>
<td>Promptly</td>
<td>Reasonable time</td>
</tr>
<tr>
<td>WYOMING</td>
<td>Promptly</td>
<td>Reasonable time</td>
</tr>
</tbody>
</table>
Acknowledgment of Claim

Under Alabama law, certain practices by insurers are considered unfair, and if committed with such frequency as to indicate a general business practice, are prohibited. See Ala. Code § 27-12-24.

A prohibited business practice shall be evidenced by (1) a substantial increase in the number of complaints against the insurer received by the insurance department; or (2) a substantial increase in the number of lawsuits against the insurer or its insured by claimants; or (3) any other relevant evidence. See Ala. Code § 27-12-24.

Prompt, Fair, and Equitable Settlement of Claim

Under Alabama law, certain practices by insurers are considered unfair, and if committed with such frequency as to indicate a general business practice, are prohibited. See Ala. Code § 27-12-24.

A prohibited business practice shall be evidenced by (1) a substantial increase in the number of complaints against the insurer received by the insurance department; or (2) a substantial increase in the number of lawsuits against the insurer or its insured by claimants; or (3) any other relevant evidence. See Ala. Code § 27-12-24.
§27-12-24. Refusal or insurer to pay or settle claims.

No insurer shall, without just cause, refuse to pay or settle claims arising under coverages provided by its policies in this state and with such frequency as to indicate a general business practice in this state, which general business practice is evidenced by:

(1) A substantial increase in the number of complaints against the insurer received by the insurance department;

(2) A substantial increase in the number of lawsuits against the insurer or its insureds by claimants; and

(3) Other relevant evidence
Acknowledgment of Claim

Under Alaska law, insurers must give written acknowledgment to all claimants within 10 working days after receipt of notification of a claim. The notification must identify the person handling the claim, including the person’s name, address, telephone number, the firm name, and the file number. Payment of the claim within 10 working days after notification is satisfactory acknowledgment. See Alaska Admin. Code tit. 3, § 26.040(a)(1). Furthermore, insurers must promptly provide all claimants with necessary claims forms, instructions, and assistance so that they may comply with any policy or contract provisions. See Alaska Admin. Code tit. 3, § 26.040(a)(3).

Also, insurer must make an appropriate reply within 15 working days after receipt to all other communications from any claimant, which reasonably indicates that a response is expected. Alaska Admin. Code tit. 3, § 26.040(a)(2).

With respect to third-party claims, all the above provisions apply. Additionally, insurers must give written acknowledgment to the insured within 10 working days after notification of a claim is received from or on behalf of an insured. See Alaska Admin. Code tit. 3, § 26.040(b)(4).

Prompt, Fair, and Equitable Settlement of Claim

Under Alaska law, insurers must advise a first-party claimant in writing of the acceptance or denial of the claim within 15 working days after receipt of a properly executed statement of claim, proof of loss, or other acceptable evidence of loss unless another time limit is specified in the policy. Payment of the claim within this time limit constitutes written acceptance. See Alaska Admin. Code tit. 3, § 26.070(a)(1).

If additional time is needed to determine whether the claim should be accepted or denied, the insurer must provide the first-party claimant with written notification within 15 working days giving the reasons that more time is needed. While the investigation remains incomplete, additional written notification shall be provided 45 working days from the initial notification, and no more than every 45 working days thereafter, giving the reasons that additional time is necessary to complete the investigation. See Alaska Admin. Code tit. 3, § 26.070(a)(1).

If there is no dispute, the claim must be paid within 30 working days. See Alaska Admin. Code tit. 3, § 26.070(a)(2).
3 AAC 26.040. **Required claim communication.**

(a) Any person transacting a business of insurance who participates in the investigation, adjustment, negotiation, or settlement of a first-party claim must:

1. within 10 working days after receipt of notification of a claim, give written acknowledgement to the first-party claimant identifying the person handling the claim, including the person’s name, address, telephone number, the firm name, and the file number; payment of the claim within 10 working days after notification is satisfactory acknowledgement; provision of necessary claim forms, written instructions, and assistance as required in (3) of this subsection is satisfactory acknowledgement; notification of a claim to an agent constitutes notification to the principal;

2. within 15 working days after receipt, make an appropriate reply to all other communications from a first-party claimant which reasonably indicates that a response is expected; receipt of a communication by an agent constitutes receipt by the principal;

3. upon receipt of notification of a claim, promptly provide necessary claim forms, instructions, and assistance so that the first-party claimant is able to comply with legal, policy, or contract provisions and other reasonable requirements.

(b) Any person transacting a business of insurance who participates in the investigations, adjustment, negotiation, or settlement of a third-party claim must:

1. within 10 working days after notification of the claim from a third-party claimant, give written acknowledgement to the third-party claimant identifying the person handling the claim, including the person’s name, address, phone number, the firm name, and the file number; payment of the claim within 10 working days after notification is satisfactory acknowledgement; provision of necessary claim forms, written instructions, and assistance as required in (3) of this subsection is satisfactory acknowledgement; notification of a claim to an agent constitutes notification to the principal;

2. within 15 working days after receipt, make an appropriate reply to all other communications from a third-party claimant which reasonably indicates that a response is expected; receipt of a communication by an agent constitutes receipt by the principal;

3. upon receipt of notification of a claim from a third-party, promptly provide necessary
claim forms, instructions and assistance that is reasonable so that the third-party claimant is able to comply with any reasonable requirement;

(4) within 10 working days after notification of a claim received from or on behalf of an insured, give written acknowledgement to the insured, identifying the person handling the claim, including the person’s name, mailing address, telephone number, the firm name, and the file number; notification of a claim to an agent constitutes notification to the principal.

(c) If notification of a claim is received in the form of a suit, a demand for arbitration, application for adjudication, or other pleading, any person transacting a business of insurance who participates in the investigation, adjustment, negotiation, or settlement of a claim shall comply with the rules of that particular forum rather than this section only so long as the claim is pending in that forum.

(d) This section does not apply to a group insurance claim subject to AS 21.54.020 or other health insurance claim for which the insurer complies with AS 21.54.020.

3 AAC 26.050. Standards for prompt investigation of claims.

(a) Any person transacting a business of insurance who participates in the investigation, adjustment, negotiation, or settlement of a claim shall promptly undertake the investigation of a claim after notification of the claim is received, and shall complete the investigation within 30 working days, unless the investigation cannot reasonably be completed using due diligence.

(b) Unless the notification of a claim is in the form of a suit, demand for arbitration, application for adjudication, or other pleading, or the claim becomes the subject of such litigation within 30 working days, the person transacting the business of insurance shall give written notification to the claimant that specifically states the need and reasons for additional investigative time and also specifies the additional time required to complete the investigation. That notification shall be given no later than the 30th working day after notification of the claim is first received.

(c) This section does not apply to a group insurance claim subject to AS 21.54.020 or other health insurance claim for which the insurer complies with AS 21.54.020.


Any person transacting a business of insurance who participates in the investigation, adjustment, negotiation, or settlement of a claim:

(1) shall fully disclose to a first-party claimant all relevant benefits and other provisions of coverage under which a claim may be covered;

(2) may not deny a claim on the ground that the first-party claimant failed to exhibit the property without written proof of demand and the unwarranted delay or refusal by the first-party claimant to do so;
(3) may not, except where there is a time limit specified in the coverage document, make statements, written or otherwise, requiring a first-party claimant to give written notice of loss, statement of claim, proof of loss, or similar affidavit within a specified time limit;

(4) may not request a first-party claimant to agree to a compromise or enter into a release that extends beyond the subject matter that gives rise to the claim payment; and

(5) may not issue a check, draft, warrant or other claim payment in partial settlement of a loss or claim under a specified coverage, which contains language that releases or compromises the issuer or its principal from any other liability.


(a) Any person transacting a business of insurance who participates in the investigation, adjustment, negotiation, or settlement of a first-party claim:

(1) shall advise a first-party claimant in writing of the acceptance or denial of the claim within 15 working days after receipt of a properly executed statement of claim, proof of loss, or other acceptable evidence of loss unless another time limit is specified in the insurance policy, insurance contract, or other coverage document; payment of the claim within this time limit constitutes written acceptance; a written denial of the claim must state the specific provisions, conditions, exclusions, and facts upon which the denial is based; if additional time is needed to determine whether the claim should be accepted or denied, written notification giving the reasons that more time is needed shall be given to the first-party claimant within the deadline. While the investigation remains incomplete, additional written notification shall be provided 45 working days from the initial notification, and no more than every 45 working days thereafter giving the reasons that additional time is necessary to complete the investigation; if there is a reasonable basis supported by specific information for suspecting that a first-party claimant has fraudulently caused or wrongfully contributed to the loss, and the basis is documented in the claim file, this reason need not be included in the written request for additional time to complete the investigation or the written denial; however, within a reasonable time for completion of the investigation and after receipt of a properly executed statement of claim, proof of loss, or other acceptable evidence of loss, the first-party claimant shall be advised in writing of the acceptance or denial of the claim;

(2) shall, within 30 working days after receipt of a properly executed statement of claim, proof of loss, or other acceptable evidence of loss, pay those portions of the claim not in dispute;

(3) may not fail to settle first-party claims on the basis that responsibility for payment must be assumed by others, except as may be expressly provided by provisions of the insurance policy, insurance contract, or other coverage document.

(b) A person transacting a business of insurance who participates in the investigation, adjustment, negotiation, or settlement of a third-party claim may not make any statement that indicates that the rights of a third-party claimant may be impaired if a form, compromise, release, or similar document is not completed within a given period of time, unless the statement is given for the purpose of notifying the third-party claimant of an applicable statute of limitation.
(c) Any person transacting a business of insurance who participates in the investigation, adjustment, negotiation, or settlement of a claim may not continue negotiations for settlement of the claim directly with any claimant who is neither an attorney nor represented by an attorney to a time when the claimant's rights might be affected by a statute of limitation, coverage provision, or other time limit, unless written notice is given to the claimant clearly stating the time limit that might be expiring and its effect upon the claim; such a written notice shall be given at least 60 calendar days before the date on which the time limit might expire.

(d) Any person transacting a business of insurance who participates in the investigation, adjustment, negotiation, or settlement of a claim shall pay a judgment or settlement of the claim (including advances, partial settlements, or similar payments) with a negotiable check payable in cash to the payee upon presentation to a bank located in Alaska. If the check is not drawn upon a bank having a physical location in Alaska, it must be payable in cash upon presentation to at least one bank having a physical location in Alaska.

(e) The provisions of (a), (b), and (c) of this section do not apply to a group insurance claim subject to AS 21.54.020 or other health insurance claim for which the insurer complies with AS 21.54.020.

ALASKA STATUTES
TITLE 21. INSURANCE.
CHAPTER 36. TRADE PRACTICES AND FRAUDS.

AS 21.36.125 Unfair claim settlement practices.

(a) A person may not commit any of the following acts or practices:

(1) misrepresent facts or policy provisions relating to coverage of an insurance policy;

(2) fail to acknowledge and act promptly upon communications regarding a claim arising under an insurance policy;

(3) fail to adopt and implement reasonable standards for prompt investigation of claims;

(4) refuse to pay a claim without a reasonable investigation of all of the available information and an explanation of the basis for denial of the claim or for an offer of compromise settlement;

(5) fail to affirm or deny coverage of claims within a reasonable time of the completion of proof-of-loss statements;

(6) fail to attempt in good faith to make prompt and equitable settlement of claims in which liability is reasonably clear;
(7) engage in a pattern or practice of compelling insureds to litigate for recovery of amounts due under insurance policies by offering substantially less than the amounts ultimately recovered in actions brought by those insureds;

(8) compel an insured or third-party claimant in a case in which liability is clear to litigate for recovery of an amount due under an insurance policy by offering an amount that does not have an objectively reasonable basis in law and fact and that has not been documented in the insurer’s file;

(9) attempt to make an unreasonably low settlement by reference to printed advertising matter accompanying or included in an application;

(10) attempt to settle a claim on the basis of an application that has been altered without the consent of the insured;

(11) make a claims payment without including a statement of the coverage under which the payment is made;

(12) make known to an insured or third-party claimant a policy of appealing from an arbitration award in favor of an insured or third-party claimant for the purpose of compelling the insured or third-party claimant to accept a settlement or compromise less than the amount awarded in arbitration;

(13) delay investigation or payment of claims by requiring submission of unnecessary or substantially repetitive claims reports and proof-of-loss forms;

(14) fail to promptly settle claims under one portion of a policy for the purpose of influencing settlements under other portions of the policy;

(15) fail 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; or

(16) offer a form of settlement or pay a judgment in any manner prohibited by AS 21.89.030;

(17) violate a provision contained in AS 21.07.

(b) The provisions of this section do not create or imply a private cause of action for a violation of this section.
Acknowledgment of Claim

Under Arizona law, insurers must acknowledge the receipt of a notification of claim within 10 working days after receiving it, unless payment is made within such period of time. See Ariz. Admin. Code § R20-6-801(E)(1).

Furthermore, insurers must promptly provide all necessary claim forms, instructions, and reasonable assistance so that first-party claimants can comply with policy conditions. Compliance with this paragraph within 10 working days of notification of a claim shall constitute compliance with the above paragraph. See Ariz. Admin. Code § R20-6-801(E)(4).

Also, insurers must make an appropriate reply within 10 working days to all other pertinent communications from a claimant which reasonably suggest that a response is expected. See Ariz. Admin. Code § R20-6-801(E)(3).

Prompt, Fair, and Equitable Settlement of a Claim

Under Arizona law, insurers must advise first-party claimants of the acceptance or denial of the claim within 15 working days after receipt by the insurer of properly executed proofs of loss. A denial must be in writing and include reference to a specific policy provision. See Ariz. Admin. Code § R20-6-801(G)(1)(a).

If more time is needed to determine acceptance or denial, the insurer must notify the first-party claimant within 15 working days after receipt of the proofs of loss, giving reasons more time is needed. See Ariz. Admin. Code § R20-6-801(G)(1)(b).

If the investigation remains incomplete, the insurer must send the claimant a letter 45 days from the date of initial notification and ever 45 days thereafter, setting forth the reasons additional time is needed for investigation. See Ariz. Admin. Code § R20-6-801(G)(1)(b).
ARIZONA ADMINISTRATIVE CODE

TITLE 20. COMMERCE, BANKING, AND INSURANCE

CHAPTER 6. DEPARTMENT OF INSURANCE

ARTICLE 8. PROHIBITED PRACTICES, PENALTIES

(Current through May 25, 2007, Volume 13, Issue 21)

R20-6-801. Unfair Claims Settlement Practices

A. Applicability.

This rule applies to all persons and to all insurance policies, insurance contracts and subscription contracts except policies of Worker’s Compensation and title insurance. This rule is not exclusive, and other acts not herein specified, may also be deemed to be a violation of A.R.S. § 20-461, The Unfair Claims Settlement Practices Act.

B. Definitions

1. "Agent" means any individual, corporation, association, partnership or other legal entity authorized to represent an insurer with respect to a claim.

2. "Claimant" means either a first party claimant, a third party claimant, or both and includes such claimant’s designated legal representative and includes a member of the claimant’s immediate family designated by the claimant.

3. "Director" means the Director of Insurance of the State of Arizona.

4. "First party claimant" means an individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy or insurance contract arising out of the occurrence of the contingency of loss covered by such policy or contract.

5. "Insurance policy or insurance contract" has the meaning of A.R.S. § 20-103.

6. "Insurer" has the meaning of A.R.S. § 20-106(C).

7. "Investigation" means all activities of an insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy or insurance contract.

8. "Notification of claim" means any notification, whether in writing or other means, acceptable under the terms of any insurance policy or insurance contract, to an insurer or its agent, by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim.
9. "Person" has the meaning of A.R.S. § 20-105.

10. "Third party claimant" means any individual, corporation, association, partnership or other legal entity asserting a claim against any individual, corporation, association, partnership or other legal entity insured under an insurance policy or insurance contract of an insurer.

11. "Worker's compensation" includes, but is not limited to, Longshoremen's and Harbor Worker's Compensation.

C. **File and record documentation.**

   The insurer’s claim files shall be subject to examination by the Director or by his duly appointed designees. Such files shall contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of such events can be reconstructed.

D. **Misrepresentation of policy provisions**

1. No insurer shall fail to fully disclose to first party claimants all pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented.

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

3. No insurer shall deny a claim on the basis that the claimant has failed to exhibit the damaged property to the insurer, unless the insurer has requested the claimant to exhibit the property and the claimant has refused without a sound basis therefore.

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 that releases the insurer or its insured from its total liability.

E. **Failure to acknowledge pertinent communications**

1. Every insurer, upon receiving notification of a claim shall, within 10 working days, acknowledge the receipt of such notice unless payment is made within such period of time.
an acknowledgment is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer.

2. Every insurer, upon receipt of any inquiry from the Department of Insurance respecting a claim shall, within fifteen working days of receipt of such inquiry, furnish the Department with an adequate response to the inquiry.

3. An appropriate reply shall be made within 10 working days on all other pertinent communications from a claimant which reasonably suggest that a response is expected.

4. Every insurer, upon receiving notification of claim, shall promptly provide necessary claim forms, instructions, and reasonable assistance so that first party claimants can comply with the policy conditions and the insurer's reasonable requirements. Compliance with this paragraph within 10 working days of notification of a claim shall constitute compliance with paragraph (1) of this subsection.

F. Standards for prompt investigation of claims.

Every insurer shall complete investigation of a claim within 30 days after notification of claim, unless such investigation cannot reasonably be completed within such time.

G. Standards for prompt, fair and equitable settlements applicable to all insurers

1. Notice of acceptance of denial of claim.

   a. Within fifteen working days after receipt by the insurer of properly executed proofs of loss, the first party claimant shall be advised of the acceptance or denial of the claim by the insurer. No insurer shall deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to such provision, condition or exclusion is included in the denial. The denial must be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial.

   b. If the insurer needs more time to determine whether a first party claim should be accepted or denied, it shall also notify the first party claimant within fifteen working days after receipt of the proofs of loss, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 45 days from the date of the initial notification and every 45 days thereafter, send to such claimant a letter setting forth the reasons additional time is needed for investigation.

   c. Where there is a reasonable basis supported by specific information available for review by the Director for suspecting that the first party claimant has fraudulently caused or contributed to the loss by arson, the insurer is relieved from the requirements of subparagraphs (a) and (b) above. Provided, however, that the claimant shall be advised of the acceptance or denial of the claim by the insurer within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.

2. If a claim is denied for reasons other than those described in subparagraph (a) above,
and is made by any other means than writing, an appropriate notation shall be made in the claim file of the insurer.

3. Insurers shall not fail to settle first party claims on the basis that responsibility for payment should be assumed by others, except as may otherwise be provided by policy provisions.

4. Insurers shall not continue negotiations for settlement of a claim directly with a claimant who is neither an attorney nor represented by an attorney until the claimant’s rights may be affected by a statute of limitations or a policy or contract time limit, without giving the claimant written notice that the time limit may be expiring and may affect the claimant’s right. Such notice shall be given to first party claimants 30 days and to third party claimants 60 days before the date on which such time limit may expire.

5. No insurer shall make statements which indicate that the rights of a third party claimant may be impaired if a form or release is not completed within a given period of time unless the statement is given for the purpose of notifying the third party claimant of the provision of a statute of limitations.
Acknowledgment of Claim

Under Arkansas law, insurers must acknowledge the receipt of a notification of claim within 15 working days of receiving it, unless payment is made within such period of time. If acknowledgment is made by means other than in writing, a notation of such acknowledgment shall be made in the insurer’s claim file. See Ark. Ins. Reg. 43, § 7(a).

Further, insurers must promptly provide all necessary claim forms, instructions, and reasonable assistance to claimants so that first-party claimants can comply with policy conditions. See Ark. Ins. Reg. 43, § 7(d).

Also, insurers must make an appropriate reply within 15 working days to all other pertinent communications from a claimant which reasonable suggest that a response is expected. See Ark. Ins. Reg. 43, § 7(c).

Prompt, Fair, and Equitable Settlement of Claim

Under Arkansas law, insurers must advise first-party claimants of the acceptance or denial of the claim within 15 working days after receipt by the insurer of properly executed proofs of loss. See Ark. Ins. Reg. 43, § 9(a)(1).

If more time is needed to determine whether a first-party claim should be accepted or denied, the insurer shall notify the claimant within 15 working days after receipt of the proofs of loss, giving reasons more time is needed. See Ark. Ins. Reg. 43, § 9(a)(2).

If the investigation remains incomplete, the insurer must send the claimant a letter 45 calendar days from the date of the initial notification and not more than every 45 calendar days thereafter, setting forth the reasons additional time is needed for investigation. See Ark. Ins. Reg. 43, § 9(a)(2).
Rule and Regulation 43. Unfair claims settlement practices

23.66.202 Purpose

(a) The purpose of this subchapter is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in Pub. L. 79-15 by defining, or providing for the determination of, all practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

(b) However, no provisions of this subchapter are intended to establish or extinguish a private right of action for a violation of any provision of this subchapter. (Private Right of Action created by Unfair Claim Settlement Practices Act, A.C.A. § 23-66-206(13)).

23-66-206 Unfair methods of competition and unfair or deceptive acts or practices defined.

(13) ‘Unfair claims settlement practices’ means committing or performing with such frequency as to indicate a general business practice any of the following:

(A) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

(B) Failing to acknowledge and act reasonably and promptly upon communications with respect to claims arising under insurance policies;

(C) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

(D) Refusing to pay claims without conducting a reasonable investigation based upon all available information;

(E) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(F) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear;

(G) Attempting to settle claims on the basis of an application that was altered without notice to, or knowledge or consent of, the insured;

(H) Making claim payments to policyholders or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made;
(l) Delaying the investigation or payment of claims by requiring an insured or claimant, or the physician of either, to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(j) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts of applicable law for denial of a claim or for the offer of a compromise settlement;

(k) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by those insureds;

(l) 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;

(M) Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

(n) Failing to promptly settle claims, when liability has become reasonably clear, under one (1) portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage; and

(o) Requiring as a condition of payment of a claim that repairs must be made by a particular contractor, supplier, or repair shop;

Arkansas State Insurance Survey

V. Claims Practices

A. Claims Resolution and Unfair Claims Settlement Practices

1. Practices generally applicable to all insurers: Prompt Investigation

Prompt Investigation and Processing of Claims

Every insurer shall complete investigation of a claim within 45 calendar days after notification of claim, unless such investigation cannot reasonably be completed within such time. If an investigation cannot be completed within the 45 day time period, insurers shall notify claimants that additional time is required and include with such notification the reasons therefore. This provision shall not apply to persons that are defined as Health Carriers under 054 00 CARR 043, § 5(m). 054 00 CARR 043, § 8.

Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies is an unfair claims settlement practice when committed or performed with such frequency as to indicate a general business practice. A.C.A. § 23-66-206(13)(C).

Delaying the investigation of claims by requiring an insured or claimant, or the physician of either, to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information is an unfair claims settlement practice when committed or performed with such frequency as to indicate a general business practice. A.C.A. § 23-66-206(13)(l).
Acknowledgment of Claim, Provision of Forms, and Notice of Time Limits

Every insurer, upon receiving notification of a claim shall, within 15 working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgement is made by means other than in writing, an appropriate notation of such acknowledgement shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer. Pursuant to Ark. Code Ann. § 23-79-126, insurers shall furnish forms for proof of loss within 20 calendar days after a loss has been reported, or thereafter waive proof of loss requirements. Insurers shall not require a claimant to calculate depreciated value of personal property on forms for proof of loss. 054 00 CARR 043, § 7(a). This provision shall not apply to persons that are defined as Health Carriers under 054 00 CARR 043, § 5(m). 054 00 CARR 043, § 7.

Failing to acknowledge and act reasonably and promptly upon communications with respect to claims arising under insurance policies is an unfair claims settlement practice when committed or performed with such frequency as to indicate a general business practice. A.C.A. § 23-66-206(13)(B).

Insurers shall not continue or prolong negotiations for settlement of a claim directly with a claimant who is neither an attorney nor represented by an attorney until the claimant’s rights may be affected by a statute of limitations or a policy or contract time limit, without giving the claimant written notice that the time limit may be expiring and may affect the claimant’s rights. Such notice shall be given to first party claimants 30 working days and to third party claimants 60 calendar days before the date on which such time limit may expire. 054 00 CARR 043, § 9(d). This provision shall not apply to persons that are defined as Health Carriers under 054 00 CARR 043, § 5(m), nor to surety and fidelity insurance, or to mortgage guaranty, or other forms of insurance offering protection against investment risks. 054 00 CARR 043, § 9.

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 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. 054 00 CARR 043, § 9(j). This provision shall not apply to persons that are defined as Health Carriers under 054 00 CARR 043, § 5(m), nor to surety and fidelity insurance, or to mortgage guaranty, or other forms of insurance offering protection against investment risks. 054 00 CARR 043, § 9.

Timely Responses to Communications

An appropriate reply shall be made within 15 working days on all other pertinent communications from a claimant which reasonably suggest that a response is expected. 054 00 CARR 043, § 7(c).This provision shall not apply to persons that are defined as Health Carriers under 054 00 CARR 043, § 5(m). 054 00 CARR 043, § 7.

Every insurer, upon receiving notification of a claim, shall promptly provide necessary claim forms, instructions, and reasonable assistance to claimants so that first party claimants can comply with the policy conditions and the insurer’s reasonable requirements. 054 00 CARR 043, § 7(d). This provision shall not apply to persons that are defined as Health Carriers under 054 00 CARR 043, § 5(m). 054 00 CARR 043, § 7.

Notification of Delays in Investigation or Additional Time/Information Required

Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first party claimant shall be advised of the acceptance or denial of the claim by the insurer. The denial must be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial. 054 00
CARR 043, § 9(a)(1). This provision shall not apply to persons that are defined as Health Carriers under 054 00 CARR 043, § 5(m), nor to surety and fidelity insurance, or to mortgage guaranty, or other forms of insurance offering protection against investment risks. 054 00 CARR 043, § 9.

If the insurer needs more time to determine whether a first party claim should be accepted or denied, it shall so notify the first party claimant in writing within 15 working days after receipt of the proofs of loss, stating the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 45 calendar days from the date of the initial notification and not more than every 45 calendar days thereafter, send to such claimant a letter setting forth the reasons additional time is needed for investigation. 054 00 CARR 043, § 9(a)(2). This provision shall not apply to persons that are defined as Health Carriers under 054 00 CARR 043, § 5(m), nor to surety and fidelity insurance, or to mortgage guaranty, or other forms of insurance offering protection against investment risks. 054 00 CARR 043, § 9.
CALIFORNIA

Acknowledgment of Claim

Under California law, insurers must acknowledge the receipt of a notification of claim within 15 calendar days after receiving it, unless payment is made within that period of time. If the acknowledgment is not in writing, a notation shall be made in the insurer’s claim file and dated. See Cal. Code Regs. tit. 10, § 2695.5(e)(1).

The insurer must also provide the claimant the necessary forms, instructions and reasonable assistance within 15 calendar days, including specifying the information the claimant must provide for proof of claim. Also, the insurer must begin any necessary investigation of the claim within the same period of time. See Cal. Code Regs. tit. 10, § 2695.5(e)(2) & (3).

Furthermore, an insurer must furnish a complete response within 15 calendar days to any communication from a claimant that suggests that a response is expected. See Cal. Code Regs. tit. 10, § 2695.5(b).

Prompt, Fair, and Equitable Settlement of Claim

Under California law, insurers must advise all claimants of the acceptance or denial of a claim within 40 calendar days of receipt of proofs of claim. See Cal. Code Regs. tit. 10, § 2695.7(b). A denial must be in writing and state reasons for denial, including reference to specific policy provisions. See Cal. Code Regs. tit. 10, § 2695.7(b)(1).

If more time is required to determine whether a claim should be accepted or denied, the insurer must provide written notice of the need for additional time within 40 calendar days of receipt of proofs of claim. The written notice shall state the reasons for insurer’s inability to make a determination. Thereafter, written notice shall be provided to the claimant every 30 calendar days until a determination is made or notice of legal action is served. See Cal. Code Regs. tit. 10, § 2695.7(c)(1).
s 2695.2. Definitions.

As used in these regulations:

(a) "Beneficiary" means:

1. for the purpose of life and disability claims, the party or parties entitled to receive the proceeds or benefits occurring under the policy in lieu of the insured; or,

2. for the purpose of surety claims, a person who is within the class of persons intended to benefit from the bond;

(b) "Calendar days" means each and every day including Saturdays, Sundays, Federal and California State Holidays, but if the last day for performance of any act required by these regulations falls on a Saturday, Sunday, Federal or State Holiday, then the period of time to perform the act is extended to and including the next calendar day which is not a Saturday, Sunday, or Federal or State holiday;

(c) "Claimant" means a first or third party claimant as defined in these regulations, any person who asserts a right of recovery under a surety bond, an attorney, any person authorized by operation of law to represent the claimant, or any of the following persons properly designated by the claimant in the manner specified in subsection 2695.5(c): an insurance adjuster, a public adjuster, or any member of the claimant’s family.

(d) "Claims agent" means any person employed or authorized by an insurer, to conduct an investigation of a claim on behalf of an insurer or a person who is licensed by the Commissioner to conduct investigations of claims on behalf of an insurer. The term "claims agent", however, shall not include the following:

1. an attorney retained by an insurer to defend a claim brought against an insured; or,

2. persons hired by an insurer solely to provide valuation as to the subject matter of a claim.
(e) "Extraordinary circumstances" means circumstances outside of the control of the licensee which severely and materially affect the licensee's ability to conduct normal business operations;

(f) "First party claimant" means any person asserting a right under an insurance policy as a named insured, other insured or beneficiary under the terms of that insurance policy, and including any person seeking recovery of uninsured motorist benefits;

(g) "Gross settlement amount" means the amount tendered plus the amount deducted as provided in the policy in the settlement of an automobile total loss claim;

(h) "Insurance agent" means:

1. the term "insurance agent" as used in section 31 of the California Insurance Code; or,

2. the term "life agent" as used in section 32 of the California Insurance Code; or,

3. any person who has authority or responsibility to notify an insurer of a claim upon receipt of a notice of claim by a claimant; or,

4. an underwritten title company.

(i) "Insurer" means a person licensed to issue or that issues an insurance policy or surety bond in this state, or that otherwise transacts the business of insurance in the state, including reciprocal and interinsurance exchanges, fraternal benefit societies, stock and mutual insurance companies, risk retention groups, California county mutual fire insurance companies, grants and annuities societies, entities holding certificates of exemption, non-profit hospital service plans, multiple employer welfare arrangements holding certificates of compliance pursuant to Article 4.7 of the California Insurance Code, and motor clubs, to the extent that they transact the business of insurance in the State. The term "insurer" for purposes of these regulations includes non-admitted insurers, the California FAIR Plan, the California Earthquake Authority, those persons licensed to issue or that issue an insurance policy pursuant to an assignment by the California Automobile Assigned Risk Plan, home protection companies as defined under California Insurance Code Section 12740, and any other entity subject to California Insurance Code Section 790.03(h). The term "insurer" shall not include insurance agents and brokers, surplus line brokers and special lines surplus line brokers.

(j) "Insurance policy" or "policy" means the written instrument in which any certificate of group insurance, contract of insurance, or non-profit hospital service plan is set forth. For the purposes of these regulations the terms insurance policy or policy do not include "surety bond" or "bond". For the purposes of these regulations the term insurance policy or policy includes a home protection contract or any written instrument in which any certificate of insurance or contract of insurance is set forth that is issued pursuant to the California Automobile Assigned Risk Plan, the California Earthquake Authority, or the California FAIR Plan;

(k) "Investigation" means all activities of an insurer or its claims agent related to the determination of coverage, liabilities, or nature and extent of loss or damage for which benefits are afforded by an
insurance policy, obligations or duties under a bond, and other obligations or duties arising from an insurance policy or bond.

(l) "Knowingly committed" means performed with actual, implied or constructive knowledge, including, but not limited to, that which is implied by operation of law.

(m) "Licensee" means any person that holds a license or Certificate of Authority from the Insurance Commissioner, or any other entity for whom the Insurance Commissioner’s consent is required before transacting business in the State of California or with California residents. The term "licensee" for purpose of these regulations does not include an underwritten title company if the underwriting agreement between the underwritten title company and the title insurer affirmatively states that the underwritten title company is not authorized to handle policy claims on behalf of the title insurer.

(n) "Notice of claim" means any written or oral notification to an insurer or its agent that reasonably apprises the insurer that the claimant wishes to make a claim against a policy or bond issued by the insurer and that a condition giving rise to the insurer’s obligations under that policy or bond may have arisen. For purposes of these regulations the term "notice of claim" shall not include any written or oral communication provided by an insured or principal solely for informational or incident reporting purposes.

(o) "Notice of legal action" means notice of an action commenced against the insurer with respect to a claim, or notice of action against the insured received by the insurer, or notice of action against the principal under a bond, and includes any arbitration proceeding;

(p) "Obligee" means the person named as obligee in a bond;

(q) "Person" means any individual, association, organization, partnership, business, trust, corporation or other entity;

(r) "Principal" means the person whose debt or other obligation is secured or guaranteed by a bond and who has the primary duty to pay the debt or discharge the obligation;

(s) "Proof of claim" means any evidence or documentation in the possession of the insurer, whether as a result of its having been submitted by the claimant or obtained by the insurer in the course of its investigation, that provides any evidence of the claim and that reasonably supports the magnitude or the amount of the claimed loss.

(t) "Remedial measures" means those actions taken by an insurer to correct or cure any error or omission in the handling of claims on the part of its insurance agent as defined in subsection 2695.2(h), including, but not limited to:

(1) written notice to the insurance agent that he/she is in violation of the regulations contained in this subchapter;

(2) transmission of a copy of the regulations contained in this subchapter and instructions for their implementation;
(3) reporting the error or omission in the handling of claims by the insurance agent to the Department of Insurance;

(u) "Replacement crash part" means a replacement for any of the non-mechanical sheet metal or plastic parts which generally constitute the exterior of a motor vehicle, including inner and outer panels;

(v) "Single act" for the purpose of determining any penalty pursuant to California Insurance Code Section 790.035 is any commission or omission which in and of itself constitutes a violation of California Insurance Code Section 790.03 or this subchapter;

(w) 'Surety bond' or 'bond' means the written instrument in which a contract of surety insurance, as defined in California Insurance Code Section 105, is set forth;

(x) "Third party claimant" means any person asserting a claim against any person or the interests insured under an insurance policy;

(y) "Willful" or "Willfully" when applied to the intent with which an act is done or omitted means simply a purpose or willingness to commit the act, or make the omission referred to in the California Insurance Code or this subchapter. It does not require any intent to violate law, or to injure another, or to acquire any advantage;

s 2695.5. Duties upon Receipt of Communications.

(a) Upon receiving any written or oral inquiry from the Department of Insurance concerning a claim, every licensee shall immediately, but in no event more than twenty-one (21) calendar days of receipt of that inquiry, furnish the Department of Insurance with a complete written response based on the facts as then known by the licensee. A complete written response addresses all issues raised by the Department of Insurance in its inquiry and includes copies of any documentation and claim files requested. This section is not intended to permit delay in responding to inquiries by Department personnel conducting a scheduled examination on the insurer's premises.

(b) Upon receiving any communication from a claimant, regarding a claim, that reasonably suggests that a response is expected, every licensee shall immediately, but in no event more than fifteen (15) calendar days after receipt of that communication, furnish the claimant with a complete response based on the facts as then known by the licensee. This subsection shall not apply to require communication with a claimant subsequent to receipt of the licensee of a notice of legal action by that claimant.

(c) The designation specified in subsection 2695.2(c) shall be in writing, signed and dated by the claimant, and shall indicate that the designated person is authorized to handle the claim. All designations shall be transmitted to the insurer and shall be valid from the date of execution until the claim is settled or the designation is revoked. A designation may be revoked by a writing transmitted to the insurer, signed and dated by the claimant, indicating that the designation is to be revoked and the effective date of the revocation.
(d) Upon receiving notice of claim, every licensee or claims agent shall immediately transmit notice of claim to the insurer.

(e) Upon receiving notice of claim, every insurer shall immediately, but in no event more than fifteen (15) calendar days later, do the following unless the notice of claim received is a notice of legal action:

1. acknowledge receipt of such notice to the claimant unless payment is made within that period of time. If the acknowledgement is not in writing, a notation of acknowledgement shall be made in the insurer’s claim file and dated. Failure of an insurance agent or claims agent to promptly transmit notice of claim to the insurer shall be imputed to the insurer except where the subject policy was issued pursuant to the California Automobile Assigned Risk Program.

2. provide to the claimant necessary forms, instructions, and reasonable assistance, including but not limited to, specifying the information the claimant must provide for proof of claim;

3. begin any necessary investigation of the claim.

(f) An insurer may not require that the notice of claim under a policy be provided in writing unless such requirement is specified in the insurance policy or an endorsement thereto.

2695.7. Standards for Prompt, Fair and Equitable Settlements.

(a) No insurer shall discriminate in its claims settlement practices based upon the claimant’s age, race, gender, income, religion, language, sexual orientation, ancestry, national origin, or physical disability, or upon the territory of the property or person insured.

(b) Upon receiving proof of claim, every insurer, except as specified in subsection 2695.7(b)(4) below, shall immediately, but in no event more than forty (40) calendar days later, accept or deny the claim, in whole or in part. The amounts accepted or denied shall be clearly documented in the claim file unless the claim has been denied in its entirety.

1. Where an insurer denies or rejects a first party claim, in whole or in part, it shall do so in writing and shall provide to the claimant a statement listing all bases for such rejection or denial and the factual and legal bases for each reason given for such rejection or denial which is then within the insurer’s knowledge. Where an insurer’s denial of a first party claim, in whole or in part, is based on a specific statute, applicable law or policy provision, condition or exclusion, the written denial shall include reference thereto and provide an explanation of the application of the statute, applicable law or provision, condition or exclusion to the claim. Every insurer that denies or rejects a third party claim, in whole or in part, or disputes liability or damages shall do so in writing.

2. Subject to the provisions of subsection 2695.7(k), nothing contained in subsection 2695.7(b)(1) shall require an insurer to disclose any information that could reasonably be expected to alert a claimant to the fact that the subject claim is being investigated as a suspected fraudulent claim.
(3) Written notification pursuant to this subsection shall include a statement that, if the claimant believes all or part of the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance, and shall include the address and telephone number of the unit of the Department which reviews claims practices.

(4) The time frame in subsection 2695.7(b) shall not apply to claims arising from policies of disability insurance subject to Section 10123.13 of the California Insurance Code, disability income insurance subject to Section 10111.2 of the California Insurance Code or mortgage guaranty insurance subject to Section 12640.09(a) of the California Insurance Code, and shall not apply to automobile repair bills arising from policies of automobile collision and comprehensive insurance subject to Section 560 of the California Insurance Code. All other provisions of subsections 2695.7(b)(1), (2), and (3) are applicable.

(c)(1) If more time is required than is allotted in subsection 2695.7(b) to determine whether a claim should be accepted and/or denied in whole or in part, every insurer shall provide the claimant, within the time frame specified in subsection 2695.7(b), with written notice of the need for additional time. This written notice shall specify any additional information the insurer requires in order to make a determination and state any continuing reasons for the insurer’s inability to make a determination. Thereafter, the written notice shall be provided every thirty (30) calendar days until a determination is made or notice of legal action is served. If the determination cannot be made until some future event occurs, then the insurer shall comply with this continuing notice requirement by advising the claimant of the situation and providing an estimate as to when the determination can be made.

(2) Subject to the provisions of subsection 2695.7(k), nothing contained in subsection 2695.7(c)(1) shall require an insurer to disclose any information that could reasonably be expected to alert a claimant to the fact that the claim is being investigated as a possible suspected fraudulent claim.

(d) Every insurer shall conduct and diligently pursue a thorough, fair and objective investigation and shall not persist in seeking information not reasonably required for or material to the resolution of a claim dispute.

(e) No insurer shall delay or deny settlement of a first party claim on the basis that responsibility for payment should be assumed by others, except as may otherwise be provided by policy provisions, statutes or regulations, including those pertaining to coordination of benefits.

(f) Except where a claim has been settled by payment, every insurer shall provide written notice of any statute of limitation or other time period requirement upon which the insurer may rely to deny a claim. Such notice shall be given to the claimant not less than sixty (60) days prior to the expiration date; except, if notice of claim is first received by the insurer within that sixty days, then notice of the expiration date must be given to the claimant immediately. With respect to a first party claimant in a matter involving an uninsured motorist, this notice shall be given at least thirty (30) days prior to the expiration date; except, if notice of claim is first received by the insurer within that thirty days, then notice of the expiration date must be given to the claimant immediately. This subsection shall not apply to a claimant represented by counsel on the claim matter.

(g) No insurer shall attempt to settle a claim by making a settlement offer that is unreasonably low. The Commissioner shall consider any admissible evidence offered regarding the following factors in determining whether or not a settlement offer is unreasonably low:
(1) the extent to which the insurer considered evidence submitted by the claimant to support the value of the claim;

(2) the extent to which the insurer considered legal authority or evidence made known to it or reasonably available;

(3) the extent to which the insurer considered the advice of its claims adjuster as to the amount of damages;

(4) the extent to which the insurer considered the advice of its counsel that there was a substantial likelihood of recovery in excess of policy limits;

(5) the procedures used by the insurer in determining the dollar amount of property damage;

(6) the extent to which the insurer considered the probable liability of the insured and the likely jury verdict or other final determination of the matter;

(7) any other credible evidence presented to the Commissioner that demonstrates that (i) any amount offered by the insurer in settlement of a first-party claim to an insured not represented by counsel, or (ii) the final amount offered in settlement of a first-party claim to an insured who is represented by counsel or (iii) the final amount offered in settlement of a third-party claim by the insurer is below the amount that a reasonable person with knowledge of the facts and circumstances would have offered in settlement of the claim.

(h) Upon acceptance of the claim in whole or in part and, when necessary, upon receipt of a properly executed release, every insurer, except as specified in subsection 2695.7(h)(1) and (2) below, shall immediately, but in no event more than thirty (30) calendar days later, tender payment or otherwise take action to perform its claim obligation. The amount of the claim to be tendered is the amount that has been accepted by the insurer as specified in subsection 2695.7(b). In claims where multiple coverage is involved, and where the payee is known, amounts that have been accepted by the insurer shall be paid immediately, but in no event more than thirty (30) calendar days, if payment would terminate the insurer's known liability under that individual coverage, unless impairment of the insured's interests would result. The time frames specified in this subsection shall not apply where the policy provides for a waiting period after acceptance of claim and before payment of benefits.

(1) The time frame specified in subsection 2695.7(h) shall not apply to claims arising from policies of disability insurance subject to Section 10123.13 of the California Insurance Code, disability income insurance subject to Section 10111.2 of the California Insurance Code, or of mortgage guaranty insurance subject to Section 12640.09(a) of the California Insurance Code, and shall not apply to automobile repair bills subject to Section 560 of the California Insurance Code. All other provisions of Section 2695.7(h) are applicable.

(2) Any insurer issuing a title insurance policy shall either tender payment pursuant to subsection 2695.7(h) or take action to resolve the problem which gave rise to the claim immediately upon, but in no event more than thirty (30) calendar days after, acceptance of the claim.

(i) No insurer shall inform a claimant that his or her rights may be impaired if a form or release is not completed within a specified time period unless the information is given for the purpose of notifying the claimant of any applicable statute of limitations or policy provision or the time limitation within which
claims are required to be brought against state or local entities.

(j) No insurer shall request or require an insured to submit to a polygraph examination unless authorized under the applicable insurance contract and state law.

(k) Subject to the provisions of subsection 2695.7(c), where there is a reasonable basis, supported by specific information available for review by the California Department of Insurance, for the belief that the claimant has submitted or caused to be submitted to an insurer a suspected false or fraudulent claim as specified in California Penal Code Section 550 or California Insurance Code Section 1871.4(a), the number of calendar days specified in subsection 2695.7(b) shall be:

1. Increased to eighty (80) calendar days; or,

2. Suspended until otherwise ordered by the Commissioner, provided the insurer has complied with California Insurance Code Section 1872.4 and the insurer can demonstrate to the Commissioner that it has made a diligent attempt to determine whether the subject claim is false or fraudulent within the eighty day period specified by subsection 2695.7(k)(1).

(l) No insurer shall deny a claim based upon information obtained in a telephone conversation or personal interview with any source unless the telephone conversation or personal interview is documented in the claim file pursuant to the provisions of Section 2695.3.

(m) No insurer shall make a payment to a provider, pursuant to a policy provision to pay medical benefits, and thereafter seek recovery or set-off from the insured on the basis that the amount was excessive and/or the services were unnecessary, except in the event of a proven false or fraudulent claim, subject to the provisions of Section 10123.145 of the California Insurance Code.

(n) Every insurer requesting a medical examination for the purpose of determining liability under a policy provision shall do so only when the insurer has a good faith belief that such an examination is reasonably necessary.

(o) No insurer shall require that a claimant withdraw, rescind or refrain from submitting any complaint to the California Department of Insurance regarding the handling of a claim or any other matter complained of as a condition precedent to the settlement of any claim.

(p) Every insurer shall provide written notification to a first party claimant as to whether the insurer intends to pursue subrogation of the claim. Where an insurer elects not to pursue subrogation, or discontinues pursuit of subrogation, it shall include in its notification a statement that any recovery to be pursued is the responsibility of the first party claimant. This subsection does not require notification if the deductible is waived, the coverage under which the claim is paid requires no deductible to be paid, the loss sustained does not exceed the applicable deductible, or there is no legal basis for subrogation.

(q) Every insurer that makes a subrogation demand shall include in every demand the first party claimant’s deductible. Every insurer shall share subrogation recoveries on a proportionate basis with the first party claimant, unless the first party claimant has otherwise recovered the whole deductible amount. No insurer shall deduct legal or other expenses from the recovery of the deductible unless the insurer has retained an outside attorney or collection agency to collect that recovery. The deduction may only be for a pro rata share of the allocated loss adjustment expense. This subsection shall not apply when multiple policies have been issued to the insured(s) covering the same loss and the language of these contracts prescribe alternative subrogation rights. Further, this subsection shall not apply to disability and health insurance as defined in California Insurance Code Section 106.
COLORADO

Acknowledgment of Claim

Under Colorado law, certain practices by insurers are considered to unfair, and if committed with such frequency as to indicate a general business practice, are prohibited. See Colo. Rev. Stat. § 10-3-1104(h).

An example of such an act is an insurer failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies. See Colo. Rev. Stat. § 10-3-1104(h)(II).

Prompt, Fair, and Equitable Settlement of Claim

Under Colorado law, certain practices by insurers are considered to unfair, and if committed with such frequency as to indicate a general business practice, are prohibited. See Colo. Rev. Stat. § 10-3-1104(h).

An example of such an act is an insurer failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed. See Colo. Rev. Stat. § 10-3-1104(h)(V).

Another example of such an act is failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies. See Colo. Rev. Stat. § 10-3-1104(h)(III).

Another example of such an act is an insurer not attempting in good faith to effectuate prompt, fair, and equitable settlements of claim in which liability has become reasonably clear. See Colo. Rev. Stat. § 10-3-1104(h)(VI).
§ 10-3-1104. Unfair methods of competition and unfair or deceptive acts or practices

(1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(a) Misrepresentations and false advertising of insurance policies: Making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, circular, statement, sales presentation, omission, or comparison which:

   (I) Misrepresents the benefits, advantages, conditions, or terms of any insurance policy; or

   (II) Misrepresents the dividends or share of the surplus to be received on any insurance policy; or

   (III) Makes any false or misleading statements as to the dividends or share of surplus previously paid on any insurance policy; or

   (IV) Is misleading or is a misrepresentation as to the financial condition of any person, or as to the legal reserve system upon which any life insurer operates; or

   (V) Uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof; or

   (VI) Is a misrepresentation for the purpose of inducing or tending to induce the lapse, forfeiture, exchange, conversion, or surrender of any insurance policy; or

   (VII) Is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any insurance policy; or

   (VIII) Misrepresents any insurance policy as being a security; or

   (IX) Misrepresentation shall not be construed where a written comparison of policies is made
(b) False information and advertising generally: Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of insurance, or with respect to any person in the conduct of his insurance business, which is untrue, deceptive, or misleading;

(c) Defamation: Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature which is false, or maliciously critical, or derogatory to the financial condition of any person, and which is calculated to injure such person;

(d) Boycott, coercion, and intimidation: Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion, or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance;

(e) Stock operations and advisory board contracts: Issuing or delivering, or permitting agents, officers, or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares, in any corporation, or securities, or any special or advisory board contracts, or other contracts of any kind promising returns and profits as an inducement to insurance;

(f) Unfair discrimination: Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity, or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract;

(II) Making or permitting any unfair discrimination between individuals of the same class or between neighborhoods within a municipality and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of insurance, or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever;

(III) Making or permitting to be made any classification solely on the basis of marital status or sex, unless such classification is for the purpose of insuring family units or is justified by actuarial statistics;

(IV) Making or permitting to be made any classification solely on the basis of blindness, partial blindness, or a specific physical disability unless such classification is based upon an unequal expectation of life or an expected risk of loss different than that of other individuals;

(VI) Inquiring about or making an investigation concerning, directly or indirectly, an applicant's, an insured's, or a beneficiary's sexual orientation in:

(A) An application for coverage; or

(B) Any investigation conducted in connection with an application for coverage;

(VII) Using information about gender, marital status, medical history, occupation, residential living arrangements, beneficiaries, zip codes, or other territorial designations to determine sexual orientation;

(VIII) Using sexual orientation in the underwriting process or in the determination of insurability;

(IX) Making adverse underwriting decisions because an applicant or an insured has demonstrated concerns related to AIDS by seeking counseling from health care professionals;

(X) Making adverse underwriting decisions on the basis of the existence of nonspecific blood code information received from the medical information bureau, but this prohibition shall not bar investigation in response to the existence of such nonspecific blood code as long as the investigation is conducted in accordance with the provisions of section 10-3-1104.5;

(XI) Reducing benefits under a health insurance policy by the addition of an exclusionary rider, unless such rider only excludes conditions which have been documented in the original underwriting application, original underwriting medical examination, or medical history of the insured, or which can be shown with clear and convincing evidence to have been caused by the medically documented excluded condition;

(XII) Denying health care coverage subject to article 16 of this title to any individual based solely on that individual's casual or nonprofessional participation in the following activities: Motorcycling; snowmobiling; off-highway vehicle riding; skiing; or snowboarding;

(g) Rebates: Except as otherwise expressly provided by law, knowingly permitting, or offering to make, or making any contract of insurance or agreement as to such contract, other than as plainly expressed in the insurance contract issued thereon, or paying, or allowing, or giving, or offering to pay, allow, or give, directly or indirectly, as inducement to such insurance or annuity, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract; or giving, or selling, or purchasing, or offering to give, sell, or purchase, as inducement to such insurance contract or annuity or in connection therewith any stocks, bonds, or other securities of any insurance company or other
corporation, association, or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract;

(h) Unfair claim settlement practices: Committing or performing, either in willful violation of this part 11 or with such frequency as to indicate a tendency to engage in a general business practice, any of the following:

(I) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue; or

(II) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies; or

(III) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies; or

(IV) Refusing to pay claims without conducting a reasonable investigation based upon all available information; or

(V) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed; or

(VI) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear; or

(VII) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds; or

(VIII) Attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application; or

(IX) Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of, the insured; or

(X) Making claims payments to insureds or beneficiaries not accompanied by statement setting forth the coverage under which the payments are being made; or

(XI) Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or
compromises less than the amount awarded in arbitration; or

(XII) Delaying the investigation or payment of claims by requiring an insured or claimant, or the physician of either of them, to submit a preliminary claim report, and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information; or

(XIII) 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; or

(XIV) 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; or

(XV) Raising as a defense or partial offset in the adjustment of a third-party claim the defense of comparative negligence as set forth in section 13-21-111, C.R.S., without conducting a reasonable investigation and developing substantial evidence in support thereof. At such time as the issue is raised under this subparagraph (XV), the insurer shall furnish to the commissioner a written statement setting forth reasons as to why a defense under the comparative negligence doctrine is valid.

(XVI) Excluding medical benefits under health care coverage subject to article 16 of this title to any covered individual based solely on that individual's casual or nonprofessional participation in the following activities: Motorcycling; snowmobiling; off-highway vehicle riding; skiing; or snowboarding;

(XVII) Failing to adopt and implement reasonable standards for the prompt resolution of medical payment claims.

(i) Failure to maintain complaint handling procedures: Failing of any insurer to maintain a complete record of all the complaints which it has received since the date of its last examination. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints, and the time it took to process each complaint. For purposes of this paragraph (i), “complaint” shall mean any written communication primarily expressing a grievance.

(j) Misrepresentation in insurance applications: Making false or fraudulent statements or representations on or relative to any application for an insurance policy, for the purpose of obtaining a fee, commission, money, or other benefit from any person;

(k) Requiring, directly or indirectly, any insured or claimant to submit to any polygraph test concerning any application for or any claim under any policy of insurance;
(l) Violation of or noncompliance with any insurance law in part 6 of article 4 of this title;

(m) Failure to make promptly a full refund or credit of all unearned premiums to the person entitled thereto upon termination of insurance coverage;

(n) Requiring or attempting to require or otherwise induce a health care provider, as defined in section 13-64-403(12)(a), C.R.S., to utilize arbitration agreements with patients as a condition of providing medical malpractice insurance to such health care provider;

(o) Failure to comply with all the provisions of section 10-3-1104.5 regarding HIV testing;

(p) Violation of or noncompliance with any provision of part 13 of this article;

(q) Increasing the premiums unilaterally or decreasing the coverage benefits on renewal of a policy of insurance, increasing the premium on new policies, or failing to issue an insurance policy to barbers, cosmetologists, cosmeticians, manicurists, barbershops, or beauty salons, as regulated in article 8 of title 12, C.R.S., regardless of the type of risk insured against, based solely on the decision of the general assembly to stop mandatory inspections of the places of business of such insureds;

(r) Advising an employer to arrange for or arranging for an employee or an employee’s dependent to apply to a plan developed pursuant to the “Colorado High Risk Health Insurance Act”, under part 5 of article 8 of this title, for the purpose of separating such employee or employee’s dependent from any group health coverage provided in connection with such employee’s employment;

(s) Certifying pursuant to section 10-16-107.2 or issuing, soliciting, or using a policy form, endorsement, or rider that does not comply with statutory mandates. Such solicitation or certification shall be subject to the sanctions described in sections 10-2-704, 10-2-801, 10-2-804, 10-3-1107, 10-3-1108, and 10-3-1109.

(t) Certifying pursuant to section 10-4-419 or issuing, soliciting, or using a claims-made policy form, endorsement, or disclosure form that does not comply with statutory mandates. Such solicitation or certification shall be subject to the sanctions described in sections 10-3-1107, 10-3-1108, and 10-3-1109.

(u) Certifying pursuant to section 10-4-633 or issuing, soliciting, or using an automobile policy form, endorsement, or notice form that does not comply with statutory mandates. Such solicitation or certification shall be subject to the sanctions described in sections 10-3-1107, 10-3-1108, and 10-3-1109.

(v) Failure to comply with all provisions of section 10-16-108.5 concerning fair marketing of basic and standard health benefit plans, and section 10-16-105 concerning guaranteed issue of basic and standard health benefit plans;
(w) Failure to comply with the provisions of section 10-16-201.5 concerning the renewability of individual health benefit plans;

(x) Violation of the provisions of part 8 of article 1 of title 25, C.R.S., concerning patient records;

(y) Violating any provision of the "Consumer Protection Standards Act for the Operation of Managed Care Plans", part 7 of article 16 of this title by those subject to said part 7;

(z) Willfully violating any provision of section 10-16-113.5;

(aa) Certifying pursuant to section 10-10-109(3) or 10-10-109(4), issuing, soliciting, or using a credit insurance policy form, certificate of insurance, notice of proposed insurance, application for insurance, endorsement, or rider that does not comply with Colorado law. Such certification, issuance, solicitation, or use shall be subject to the sanctions described in sections 10-3-1107, 10-3-1108, and 10-3-1109.

(bb) Certifying pursuant to section 10-15-105(1), issuing, soliciting, or using a preneed funeral contract form or a form of assignment that does not comply with Colorado law. Such certification, issuance, solicitation, or use shall be subject to the sanctions described in sections 10-3-1107, 10-3-1108, and 10-3-1109.

(cc) Violation of the provisions of section 10-16-122(4) concerning an unauthorized transfer of a covered person or subscriber's prescription;

(dd) Failing to comply with the provisions of section 10-4-628(2)(a)(V) or 10-16-201(5);

(ee) Willfully or repeatedly violating section 10-11-108(1)(c) or (1)(d), including a willful or repeated violation through the creation or operation of an improper affiliated business arrangement.

(2) Nothing in paragraph (f) or (g) of subsection (1) of this section shall be construed as including within the definition of discrimination or rebates any of the following practices:

(a) In the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, if any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders;

(b) In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expenses;
(c) Readjustment of the rate of premium for a group insurance policy based on the loss or expense thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year;

(d) Requests by a person that an applicant or insured take an HIV related test when such request has been prompted by either the health history or current condition of the applicant or insured or by threshold coverage amounts which are applied to all persons within the risk class, as long as such test is conducted in accordance with the provisions of section 10-3-1104.5.


(4) The following is defined as an unfair practice in the business of insurance: For an insurer to deny, refuse to issue, refuse to renew, refuse to reissue, cancel, or otherwise terminate a motor vehicle insurance policy, to restrict motor vehicle insurance coverage on any person, or to add any surcharge or rating factor to a premium of a motor vehicle insurance policy solely because of:

(a) A conviction under section 12-47-901(1)(b), C.R.S., or section 18-13-122(2), C.R.S., or any counterpart municipal charter or ordinance offense or because of any driver’s license revocation resulting from such conviction. This paragraph (a) includes, but is not limited to, a driver’s license revocation imposed under section 42-2-125(1)(m), C.R.S.

(b) The licensee’s inability to operate a motor vehicle due to physical incompetence if the licensee obtains an affidavit from a rehabilitation provider or licensed physician acceptable to the department of revenue.

(5) It shall not be an unfair practice in the business of insurance for an insurer to pay an assignee if the insurer believes in good faith that the claim is subject to a written assignment from the insured. The insurer shall remain responsible to the insured for such amounts pursuant to the applicable policy terms in the event the person paid did not hold a written assignment and did not provide services or goods to the insured at the insured’s request.

Note also – amended regulation 5-1-14 (penalties for failure to promptly address property and casualty first party claims)
Acknowledgment of Claim

Under Connecticut law, certain practices by insurers are considered unfair, and if committed with such frequency as to indicate a general business practice, are prohibited. See Conn. Gen. Stat. § 38a-816(6).

An example of such an act is an insurer failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies. See Conn. Gen. Stat. § 38a-816(6)(b).

Prompt, Fair, and Equitable Settlement of Claim

Under Connecticut law, certain practices by insurers are considered unfair, and if committed with such frequency as to indicate a general business practice, are prohibited. See Conn. Gen. Stat. § 38a-816(6).

An example of such an act is failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies. See Conn. Gen. Stat. § 38a-816(6)(c).

Another example of such an act is an insurer failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed. See Conn. Gen. Stat. § 38a-816(6)(e).

Another example of such an act is an insurer not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear. See Conn. Gen. Stat. § 38a-816(6)(f).
§ 38a-816. Unfair practices defined

The following are defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

(6) **Unfair claim settlement practices.** Committing or performing with such frequency as to indicate a general business practice any of the following:

(a) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

(b) failing to acknowledge and act with reasonable promptness upon communications with respect to claims arising under insurance policies;

(c) failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

(d) refusing to pay claims without conducting a reasonable investigation based upon all available information;

(e) failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(f) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;

(g) compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds;

(h) attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application;

(i) attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of the insured;

(j) making claims payments to insureds or beneficiaries not accompanied by statements setting forth the coverage under which the payments are being made;

(k) making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

(l) delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;
(m) 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;

(n) 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;

(o) using as a basis for cash settlement with a first party automobile insurance claimant an amount which is less than the amount which the insurer would pay if repairs were made unless such amount is agreed to by the insured or provided for by the insurance policy.
Acknowledgment of Claim

Under Delaware law, any single act or omission by an insurer isn’t by itself a violation. However, certain claim settlement practices, when committed with such frequency as to indicate a general business practice, are considered unfair and are prohibited. See 18 900 902 Del. Code Regs. § 1.2.1.

One such example is an insurer failing to acknowledge and respond within 15 working days to any communications relating to claims by insureds under insurance policies. See 18 900 902 Del. Code Regs. § 1.2.1.2.

Prompt, Fair, and Equitable Settlement of Claim

Under Delaware law, any single act or omission by an insurer isn’t by itself a violation. However, certain claim settlement practices, when committed with such frequency as to indicate a general business practice, are considered unfair and are prohibited. See 18 900 902 Del. Code Regs. § 1.2.1.

One such example is an insurer failing to implement prompt investigation of claims arising under insurance policies within 10 working days upon receipt of the notice of loss by the insurer. See 18 900 902 Del. Code Regs. § 1.2.1.3

Another example of a prohibited insurance practice is an insurer failing to affirm or deny coverage or a claim or advise the person presenting the claim, in writing, or other proper legal manner, of the reason for the inability to do so, within 30 days after proof of loss statements have been received by the insurer. See 18 900 902 Del. Code Regs. § 1.2.1.5.
18 900 902. Prohibited Unfair Claim Settlement Practices

Claim Settlement Practices Which, When Committed Or Performed with Such Frequency as to Indicate a General Business Practice, Are Prohibited

1.0 Authority for Regulation; Basis for Regulation

1.1 18 Del.C. §314 authorizes the Insurance Commissioner to "...make reasonable rules and regulations necessary for or as an aid to the administration or effectuation of any provision of this title."


1.2.1 The Following Claim Settlement Practices When Committed or Performed with such Frequency as to Indicate a General Practice are Prohibited:

1.2.1.1 Misrepresenting pertinent facts or insurance policy provisions relating to coverage at issue.

1.2.1.2 Failing to acknowledge and respond within 15 working days, upon receipt by the insurer, to communications with respect to claims by insureds arising under insurance policies.

1.2.1.3 Failing to implement prompt investigation of claims arising under insurance policies within 10 working days upon receipt of the notice of loss by the insurer.

1.2.1.4 Refusing to pay claims without conducting an investigation based upon all available information when the notice of loss received by the insurer indicates that such an investigation is necessary to properly determine such a denial of payment.

1.2.1.5 Failing to affirm or deny coverage or a claim or advise the person presenting the claim, in writing, or other proper legal manner, of the reason for the inability to do so, within 30 days after proof of loss statements have been received by the insurer.

1.2.1.6 Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims in which liability has become clear.

1.2.1.7 Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts which they might be entitled to under normal fair claims evaluations.
1.2.1.8 Attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application.

1.2.1.9 Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge of the insured.

1.2.1.10 Making claims payments to insured or beneficiaries not accompanied by a statement setting forth the coverage under which the payment has been made.

1.2.1.11 Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of a formal proof of loss form, both of which submissions contain substantially the same information, unless the formal proof of loss is required by law, prevailing rules, or the policy.

1.2.1.12 Failing to promptly settle claims, where liability has become clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

1.2.1.13 Failing when requested to promptly provide an explanation of the basis in the insurance policy in relation to facts or applicable law for denial of a claim or for the offer of a compromise settlement. Such explanation may be made verbally but when given, must be documented in the claims file.

2.0 Violations; Penalties

2.1 Failure to comply will subject the violators to the provisions of 18 Del. C. §1732 (c)(2) and § 2307(a) which deals with hearings, license revocation, suspension or fine for non-compliance of any regulation.

3.0 Severability

3.1 If any provision of this Regulation shall be held invalid, the remainder of the Regulation shall not be affected thereby.

4.0 Effective Date

4.1 This Regulation shall become effective August 1, 1977.
Acknowledgment of Claim

Under Florida law, an insurer must review and acknowledge receipt of all communications with respect to claims within 14 calendar days, unless payment is made during such period of time or unless the failure to acknowledge is caused by factors beyond the control of the insurer which reasonably prevent such acknowledgment. If the acknowledgment is not in writing, a notification indicating acknowledgment must be made in the insurer’s claim file and dated. See Fla. Admin. Code Ann. r. 69B-166.024(1).

Such acknowledgment must be responsive to the communication. If the communication constitutes a notification of claim, the insurer shall provide necessary claim forms, instructions, and appropriate telephone number. See Fla. Admin. Code Ann. r. 69B-166.024(2).

Prompt, Fair and Equitable Settlement of Claim

Under Florida law, unless otherwise provided by the policy of insurance or by statutes, an insurer must within 10 working days of its receipt of proof of loss statements begin such investigation as is reasonably necessary, unless the failure to begin such investigation is caused by factors beyond the control of the insurer which reasonably prevent the commencement of such investigation. See Fla. Admin. Code Ann. r. 69O-166.024(3).
69B-166.021. Definitions.

As used in this part:

(1) "Person" means any individual, association, organization, partnership, business, trust, or corporation.

(2) "Agent" means any person, as defined herein, authorized to represent an insurer with respect to a claim, including adjusters.

(3) "Claimant" means a first-party claimant, a third-party claimant, and, where the claimant is an individual, a member of the claimant's family designated by the claimant.

(4) "First-party claimant" means any person asserting a right to payment as an insured as provided by the insurance policy, arising out of the occurrence of the contingency or loss covered by that policy.

(5) "Insurer" means a person authorized to issue or which issues an insurance policy in this state, or otherwise transacts insurance in this state, including reciprocal and interinsurance exchanges, fraternal benefit societies, stock and mutual insurance companies, mutual fire insurance companies, grants and annuities societies, insurers holding certificates of exemption, motor clubs, medical and health service and related service plans, or the agents of any of the above-designated persons. The term "insurer," for purposes of this part, shall not include surplus lines brokers.

(6) "Insurance policy" and "policy" refer to the written instrument in which any certificate of insurance, contract of insurance, hospital service plan or motor club service is set forth.

(7) "Investigation" means any activities of an insurer or its agent, directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy, and other obligations or duties arising from an insurance policy.

(8) "Notification of a claim" means any notice to an insurer or its agent by a claimant or an insured that reasonably apprises the insurer that a loss has occurred.
(9) "Notice of loss" means:

(a) Written notice, such as claim forms, medical bills, medical authorizations or other reasonable evidence of the claim that is ordinarily required of a claimant; or,

(b) Any notice by or on behalf of a claimant that reasonably apprises the insurer that a loss has occurred and that the claimant wishes to make a claim under an insurance policy or against a person insured under an insurance policy for such loss.

(10) "Tender" shall include mailing to the last known address or designated address of the last known recipient, or otherwise effecting delivery.

(11) "Third-party claimant" means any person asserting a claim against any other person insured under an insurance policy or insurance contract of an insurer.

(12) "Department" means the Department of Financial Services.

69B-166.024. Failure to Acknowledge Communications and Act Promptly as to Communications with Respect to Claims and to Implement Standards for the Prompt Investigation of Claims.

Every insurer shall adopt and implement standards for the acknowledgement of communications and investigation of claims with respect to claims so that:

1. Upon the insurer’s receiving a communication with respect to a claim, it shall, within 14 calendar days, review and acknowledge receipt of such communication unless payment is made within that period of time or unless the failure to acknowledge is caused by factors beyond the control of the insurer which reasonably prevent such acknowledgment. If the acknowledgment is not in writing, a notification indicating acknowledgment shall be made in the insurer’s claim file and dated. A communication made to or by an agent of an insurer with respect to a claim shall constitute communication to or by the insurer. As used in this subsection, “agent” means any person to whom an insurer has granted authority or responsibility to receive or make such communications with respect to claims on behalf of the insurer. This subsection shall not apply to claimants represented by counsel beyond those communications necessary to provide forms and instructions.

2. Such acknowledgment shall be responsive to the communication. If the communication constitutes a notification of a claim, unless the acknowledgment reasonably advises the claimant that the claim appears not to be covered by the insurer, it shall provide necessary claim forms, and instructions, including an appropriate telephone number.

3. Unless otherwise provided by the policy of insurance or by statutes, such insurer shall within 10 working days of its receipt of proof of loss statements begin such investigation as is reasonably necessary, unless the failure to begin such investigation is caused by factors beyond the control of the insurer which reasonably prevent the commencement of such investigation.
69O-166.021. Definitions.

As used in this part:

(1) "Person" means any individual, association, organization, partnership, business, trust, or corporation.

(2) "Agent" means any person, as defined herein, authorized to represent an insurer with respect to a claim, including adjusters.

(3) "Claimant" means a first-party claimant, a third-party claimant, and, where the claimant is an individual, a member of the claimant's family designated by the claimant.

(4) "First-party claimant" means any person asserting a right to payment as an insured as provided by the insurance policy, arising out of the occurrence of the contingency or loss covered by that policy.

(5) "Insurer" means a person authorized to issue or which issues an insurance policy in this state, or otherwise transacts insurance in this state, including reciprocal and interinsurance exchanges, fraternal benefit societies, stock and mutual insurance companies, mutual fire insurance companies, grants and annuities societies, insurers holding certificates of exemption, motor clubs, medical and health service and related service plans, or the agents of any of the above-designated persons. The term "insurer," for purposes of this part, shall not include surplus lines brokers.

(6) "Insurance policy" and "policy" refer to the written instrument in which any certificate of insurance, contract of insurance, hospital service plan or motor club service is set forth.

(7) "Investigation" means any activities of an insurer or its agent, directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy, and other obligations or duties arising from an insurance policy.

(8) "Notification of a claim" means any notice to an insurer or its agent by a claimant or an insured that reasonably apprises the insurer that a loss has occurred.

(9) "Notice of loss" means:

(a) Written notice, such as claim forms, medical bills, medical authorizations or other reasonable evidence of the claim that is ordinarily required of a claimant; or,
(b) Any notice by or on behalf of a claimant that reasonably apprises the insurer that a loss has occurred and that the claimant wishes to make a claim under an insurance policy or against a person insured under an insurance policy for such loss.

(10) "Tender" shall include mailing to the last known address or designated address of the last known recipient, or otherwise effecting delivery.
(11) "Third-party claimant" means any person asserting a claim against any other person insured under an insurance policy or insurance contract of an insurer.

(12) "Office" means the Office of Insurance Regulation.

69O-166.024. Failure to Acknowledge Communications and Act Promptly as to Communications with Respect to Claims and to Implement Standards for the Prompt Investigation of Claims.

Every insurer shall adopt and implement standards for the acknowledgement of communications and investigation of claims with respect to claims so that:

(1) Upon the insurer's receiving a communication with respect to a claim, it shall, within 14 calendar days, review and acknowledge receipt of such communication unless payment is made within that period of time or unless the failure to acknowledge is caused by factors beyond the control of the insurer which reasonably prevent such acknowledgement. If the acknowledgement is not in writing, a notification indicating acknowledgement shall be made in the insurer's claim file and dated. A communication made to or by an agent of an insurer with respect to a claim shall constitute communication to or by the insurer. As used in this subsection, "agent" means any person to whom an insurer has granted authority or responsibility to receive or make such communications with respect to claims on behalf of the insurer. This subsection shall not apply to claimants represented by counsel beyond those communications necessary to provide forms and instructions.

(2) Such acknowledgement shall be responsive to the communication. If the communication constitutes a notification of a claim, unless the acknowledgement reasonably advises the claimant that the claim appears not to be covered by the insurer, it shall provide necessary claim forms, and instructions, including an appropriate telephone number.

(3) Unless otherwise provided by the policy of insurance or by statutes, such insurer shall within 10 working days of its receipt of proof of loss statements begin such investigation as is reasonably necessary, unless the failure to begin such investigation is caused by factors beyond the control of the insurer which reasonably prevent the commencement of such investigation.
Acknowledgment of Claim

The following relates to first-party property damage claims:

Under Georgia law, insurers must acknowledge the receipt of a notification of claim within 15 days after receiving such notice by the insured, unless payment is made within such period of time. If acknowledgment is made by means other than writing, a notation of the acknowledgment must be made in the claim file of the insurer and dated. See Ga. Comp. R. & Regs. r. 120-2-52-.03(1).

Also, insurers must provide the insured with proof of loss forms and reasonable explanations regarding their use within 15 days of receipt of notification of claim. Providing these forms constitutes compliance with the paragraph above. See Ga. Comp. R. & Regs. r. 120-2-52-.03(2).

Prompt, Fair and Equitable Settlement of Claim

Under Georgia law, insurers must affirm or deny liability on claims within 15 days of receiving the completed proof of loss from the insured. If the insurer does not require the proof of loss to be completed, the affirmation or denials of liability must be within 30 days from the day the claim was reported to the insurer. See Ga. Comp. R. & Regs. r. 120-2-52-.03(3).

If the insurer needs more time than that specified in the preceding paragraph to determine whether a first-party claim should be accepted or denied, the insurer must notify the claimant within 5 business days after the time limitation has elapsed in the preceding paragraph. The notice must state the reason that more time is needed and an estimate of additional time needed to establish liability. See Ga. Comp. R. & Regs. r. 120-2-52-.03(5).

The notice described in the preceding paragraph can be accomplished by writing or if by other means, a proper notation shall be made in the insurer’s claim file and dated. The total time an insurer has to accept or deny liability shall not exceed 60 days from the insurer being notified of the claim, unless the insurer has documented the claim file where information that has been requested necessary to determine liability has not been submitted. See Ga. Comp. R. & Regs. r. 120-2-52-.03(5).
120-2-52-.03. Standards for prompt and fair settlements of first party property damage claims

(1) Every insurer, upon receiving notification of a claim shall, within fifteen (15) days, acknowledge the receipt of such notice by the insured, unless payment is made within that time period. If an acknowledgment is made by means other than writing, a notation of the acknowledgment shall be made in the claim file of the insurer and dated. Notification of a claim given to an agent of an insurer shall be notification to the insurer.

(2) Every insurer, upon receiving notification of a claim shall, within fifteen (15) days, provide the insured with the proof of loss forms, if applicable, with reasonable explanations regarding their use. The providing of these forms will constitute an acknowledgement of receipt of the claim referred to in paragraph (1) above.

(3) The insurer shall affirm or deny liability on claims within fifteen (15) days of receiving the completed proof of loss from the insured. If the insurer does not require the proof of loss to be completed, the affirmation or denial of liability shall be within thirty (30) days from the day the claim was reported to the insurer.

(4) Payment shall be tendered within ten (10) days after coverage is confirmed and the full amount of the claim is determined and not in dispute. In claims where multiple coverages are involved, payments for individual coverages, which are not in dispute and where the payee is known, shall be tendered within ten (10) days, if such payment would terminate the insurer’s known liability under that individual coverage.

(5) If the insurer needs more time than that specified in paragraph (3) above, to determine whether a first party claim should be accepted or denied, it shall notify the claimant within five (5) business days after the time limitation has elapsed in paragraph (3) above giving the reason that more time is needed and an estimate of additional time needed to establish liability. This can be accomplished in writing or if by other means, a proper notation shall be made in the claim file and dated. The total time the insurer has to accept or deny liability shall not exceed 60 days from the company being notified of the claim, unless the company has documented the claim file where information that has been requested necessary to determine liability has not been submitted.

(6) If the insurer has affirmed liability on a claim, or affirmed liability for individual coverages where the claim involves multiple coverages and the amount payable is in dispute, the insured, or the insurer, may submit to the Commissioner a request for their case to be arbitrated. The request must be in writing and must include the facts of the case to include where each party currently stands in the negotiations. The Commissioner may establish a panel of arbitrators consisting of attorneys authorized...
to practice law in this State and insurance adjusters licensed to act as such in this State. The arbitrators will be charged with the duty of establishing a fair and equitable monetary settlement of the case. If an arbitration panel has been established, three (3) individuals from the panel of arbitrators, at least one of whom shall be an attorney authorized to practice law in this State and at least one of whom shall be an insurance adjuster licensed to act as such in this State, will be designated to hear each request for arbitration. Any claim settled pursuant to this Chapter shall be binding on both parties and fulfill any arbitration provision currently contained in the motor vehicle insurance policy, but shall not preclude or waive any other rights either party has under common law. The decision of the arbitration panel shall in no way be construed as a decision of the Commissioner. If an arbitration panel has been established, the Commissioner shall forward the written request for arbitration to the three (3) individuals selected to hear such request. The cost of the arbitration shall be borne equally by the parties to the arbitration.

(7) No insurer shall deny a claim on the grounds of a specific policy provision, condition or exclusion unless reference to such provision, condition, or exclusion is included in the denial. The denial shall be given to the insured in writing and the claim file of the insurer shall contain documentation of the denial.

(8) The insurer shall pay according to the terms of its policy for the covered loss up to the actual cash value to repair or to replace the damaged or stolen property subject to any deductibles. However, the insured has the right to choose the place of repair and pay the difference in cost, if the cost of the repair shop selected by the insured is greater than that obtained by the insurer.

(a) Unless permitted pursuant to the provisions of the policy of insurance, no insurer shall require an insured to utilize a particular person, firm, or corporation to repair a motor vehicle in order to settle a first party claim if the insured can obtain the repair work on the motor vehicle at the same cost from another source.
Acknowledgment of Claim

Under Hawaii law, certain practices committed by an insurer with respect to claims, if performed with such frequency as to indicate a general business practice, are defined as unfair and deceptive practices and are prohibited. See Haw. Rev. Stat. § 431:13-103(a)(11).

One such practice is failing to acknowledge within 15 working days any communications with respect to claims arising under its policies from policyholders, the Insurance Commissioner or any other person. See Haw. Rev. Stat. § 431:13-103(a)(11)(B).

The response from the insurer shall be more than an acknowledgment that such person’s communication was received, and shall adequately address the concerns stated in the communication. See Haw. Rev. Stat. § 431:13-103(a)(11)(B).

Prompt, Fair and Equitable Settlement of Claim

Under Hawaii law, certain practices committed by an insurer with respect to claims, if performed with such frequency as to indicate a general business practice, are defined as unfair and deceptive practices and are prohibited. See Haw. Rev. Stat. § 431:13-103(a)(11).

One such practice is failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under policies. See Haw. Rev. Stat. § 431:13-103(a)(11)(C).

Another such practice is failing to affirm or deny coverage of claims within a reasonable time after proofs of loss have been completed. See Haw. Rev. Stat. § 431:13-103(a)(11)(E).

Another such practice is failing to provide the insured with a reasonable written explanation for delay on every claim remaining unresolved for 30 calendar days from the date it was reported. See Haw. Rev. Stat. § 431:13-103(a)(11)(G).
§ 431:13-103 Unfair methods of competition and unfair or deceptive acts or practices defined.

(a) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

11) Unfair claim settlement practices. Committing or performing with such frequency as to indicate a general business practice any of the following:

(A) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue

(B) With respect to claims arising under its policies, failing to respond with reasonable promptness, in no case more than fifteen working days, to communications received from:

(i) The insurer’s policyholder;

ii) Any other persons, including the commissioner; or

(iii) The insurer of a person involved in an incident in which the insurer’s policyholder is also involved.

The response shall be more than an acknowledgment that such person’s communication has been received, and shall adequately address the concerns stated in the communication;

(C) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

(D) Refusing to pay claims without conducting a reasonable investigation based upon all available information;

(E) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(F) Failing to offer payment within thirty calendar days of affirmation of liability, if the amount of the claim has been determined and is not in dispute;

(G) Failing to provide the insured, or when applicable the insured’s beneficiary, with a reasonable written explanation for any delay, on every claim remaining unresolved for thirty calendar days from the date it was reported;

(H) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which
liability has become reasonably clear;

(I) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by the insureds;

(J) Attempting to settle a claim for less than the amount to which a reasonable person would have believed the person was entitled by reference to written or printed advertising material accompanying or made part of an application;

(K) Attempting to settle claims on the basis of an application which was altered without notice, knowledge, or consent of the insured;

(L) Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which the payments are being made;

(M) Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

(N) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(O) Failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage to influence settlements under other portions of the insurance policy coverage;

(P) 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; and

(Q) Indicating to the insured on any payment draft, check, or in any accompanying letter that the payment is ‘final’ or is ‘a release’ of any claim if additional benefits relating to the claim are probable under coverages afforded by the policy; unless the policy limit has been paid or there is a bona fide dispute over either the coverage or the amount payable under the policy;
Acknowledgment of Claim

Under Idaho law, certain practices committed by an insurer with respect to claims, if performed with such frequency as to indicate a general business practice, are defined as unfair and deceptive practices and are prohibited. See Idaho Code § 41-1329.

One such practice is failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under policies. See Idaho Code § 41-1329(2).

Prompt, Fair and Equitable Settlement of Claim

Under Idaho law, certain practices committed by an insurer with respect to claims, if performed with such frequency as to indicate a general business practice, are defined as unfair and deceptive practices and are prohibited. See Idaho Code § 41-1329.

One such practice is failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under policies. See Idaho Code § 41-1329(3).

Another such practice is failing to affirm or deny coverage of claims within a reasonable time after proof of loss requirements under the policy have been completed and submitted by the insured. See Idaho Code § 41-1329(5).

Another such practice is not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear. See Idaho Code § 41-1329(6).
41-1329 Unfair claim settlement practices.

Pursuant to section 41-1302, Idaho Code, committing or performing any of the following acts or omissions intentionally, or with such frequency as to indicate a general business practice shall be deemed to be an unfair method of competition or an unfair or deceptive act or practice in the business of insurance:

1. Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

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 based upon all available information;

5. Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

6. Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;

7. Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds;

8. Attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application;

9. Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of the insured;

10. Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which the payments are being made;
(11) Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

(12) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(13) 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; or

(14) 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.
Acknowledgment of Claim

Under Illinois law, an insurer must use “reasonable promptness” when communicating with a claimant or insured. Reasonable promptness is defined as a maximum of 15 working days from receipt of a pertinent communication from a claimant or insured. Pertinent communication includes all correspondence, regardless of source or type, which is materially related to the handling of a claim. See Ill. Admin. Code tit. 50, § 919.40.

Prompt, Fair and Equitable Settlement of Claim

Under Illinois law, an insurer must conduct a “prompt investigation,” which applies to all activities of the insured related directly or indirectly to the determination of liability based on claims under the coverage afforded by the policy and shall be evidenced by a bona fide effort to communicate with all insureds and claimants where eligibility is reasonably clear within 21 working days after a notification of loss. See Ill. Admin. Code tit. 50, § 919.40.

Furthermore, an insurer must affirm or deny liability on claims within a reasonable time and shall offer payment within 30 days of affirmation of liability, if the amount of claim is determined and not in dispute. For those portions of the claim which are not in dispute and the payee is known, the insurer shall tender payment within 30 days. See Ill. Admin. Code tit. 50, § 919.50(a).

On first-party claims if a settlement of a claim is less than the amount claimed, or if the claim is denied, the insurer must provide to the insured a reasonable written explanation of the basis of the lower offer or denial within 30 days after the investigation and determination of liability is completed. See Ill. Admin. Code tit. 50, § 919.50(a)(1).

With respect to third-party claims, within 30 days after the initial determination of liability is made, if the claim is denied the insurer must provide the third-party a reasonable written explanation of the basis of the denial. See Ill. Admin. Code tit. 50, § 919.50(a)(2).
919.40 Definitions/Explanations


Company refers to any licensee of the Department of Insurance, including health maintenance organizations.

Days for the purpose of this Part, means calendar days.

Department means the Illinois Department of Insurance.

Director means the Director of the Illinois Department of Insurance.

Documentation shall mean all pertinent communications, transactions, notes and work papers. All such communications, transactions, notes and work papers shall be properly dated and compiled in sufficient detail in order to allow for the reconstruction of all pertinent events relative to each claim file. Documentation shall include but not be limited to bills, explanations of benefits and worksheets.

First Party means to any individual, corporation, association, partnership, or other legal entity asserting a contractual right to payment under an insurance policy or insurance contract arising out of the contingency or loss covered by such policy or contract.

Insured shall mean, for the purposes of life, accident and health insurance or other health care or service plans, the party named on a contract as the individual, corporation or association with legal rights to the benefits provided by such contract. This includes certificate holders or subscribers to a group contract and enrollees of a health maintenance organization, any other type of health care or service plans, or third party administrator. For purposes of property and casualty insurance, the party named on the contract is the insured.

Non-Original Manufacturer means any manufacturer other than the manufacturer of the original part.

Notice of Availability of the Department of Insurance as required by this Part shall be no less informative than the following:
Part 919 of the Rules of the Illinois Department of Insurance requires that our company advise you that if you wish to take this matter up with the Illinois Department of Insurance, it maintains a Consumer Division in Chicago at 100 W. Randolph Street, Suite 15-100, Chicago, Illinois 60601 and in Springfield at 320 West Washington Street, Springfield, Illinois 62767.

Notification of Loss shall mean communication, as required by the policy or that is otherwise acceptable by the insurer, from a claimant or insured to the insurer which identifies the claimant or insured and indicates that a loss has occurred or is about to occur.

**Pertinent Communication**, as used in Section 154.6(b) of the Code (215 ILCS 5/154.6(b)) , shall include all correspondence, regardless of source or type, that is materially related to the handling of the claim.

Policy, for the purpose of this Part, shall mean a policy, certificate or contract issued to Illinois residents, including a certificate of enrollment into a health maintenance organization or any other type of health care or service plan.

Private Passenger Automobile refers to vehicles insured under a policy of automobile insurance as defined in Section 143.13 of the Code (215 ILCS 5/143.13).

**Prompt Investigation**, as used in Section 154.6(c) of the Code (215 ILCS 5/154.6(c)) , shall apply to all activities of the company related directly or indirectly to the determination of liability based on claims under the coverage afforded by the policy and shall be evidenced by a bonafide effort to communicate with all insureds and claimants where liability is reasonably clear within 21 working days after a notification of loss. Evidence of such bonafide effort to communicate with insureds and claimants shall be maintained in the company's claim files.

**Reasonable Promptness**, as used in Section 154.6(b) of the Code (215 ILCS 5/154.6(b)) , shall mean a maximum of 15 working days from receipt of communication from a claimant or insured.

Replacement Crash Parts, for purposes of this Part, means sheet metal or synthetic parts, e.g., plastic, fiberglass, etc., that constitute the exterior of a motor vehicle, including inner and outer panels.

Representative shall include any person expressly authorized to act on behalf of the insurer and any employee of the insurer who acts or appears to act on behalf of the insurer in matters relating to claims, including but not limited to independent contractors while performing claim services at the direction of the company.

Settlement of Claims, as used in Section 154.6(c) of the Code (215 ILCS 5/154.6(c)) , shall pertain to all activities of the company or its representatives, relating directly or indirectly to the determination of the extent of liabilities due or potentially due under coverages afforded by the policy, evidence of such activities to be maintained in the company’s claim files.

Third Party refers to any individual, corporation, association, partnership, or other legal entity asserting a claim against any individual, corporation, partnership, or other legal entity insured under a policy.

**919.50 Required Practices for all Insurance Companies**
a) The company shall affirm or deny liability on claims within a reasonable time and shall offer payment within 30 days after affirmation of liability, if the amount of the claim is determined and not in dispute. For those portions of the claim which are not in dispute and for which the payee is known, the company shall tender payment within said 30 days.

   1) On first party claims if a settlement of a claim is less than the amount claimed, or if the claim is denied, the company shall provide to the insured a reasonable written explanation of the basis of the lower offer or denial within 30 days after the investigation and determination of liability is completed. This explanation shall clearly set forth the policy definition, limitation, exclusion or condition upon which denial was based. Notice of Availability of the Department of Insurance shall accompany this explanation.

   2) Within 30 days after the initial determination of liability is made, if the claim is denied, the company shall provide the third party a reasonable written explanation of the basis of the denial.

b) No company shall deny a claim upon information obtained in a telephone conversation or personal interview with any source unless such telephone conversation or personal interview is documented in the claim file.

c) The company’s standards for claims processing shall be such that notice of claim and proofs of loss submitted against one policy issued by that company shall fulfill the insured’s obligation under any and all similar policies issued by that company and specifically identified by the insured to said company to the same degree that the same form would be required under any similar policy. If additional information is required to fulfill the insured’s obligation under other similar policies, the company may request the additional information. When it is apparent to the company that additional benefits would be payable under an insured’s policy upon receipt of additional proofs of loss from the insured, the company shall communicate to and cooperate with the insured in determining the extent of the company’s additional liability.
Acknowledgment of Claim

Under Indiana law, certain practices committed by an insurer with respect to claims are defined as unfair and deceptive practices and are prohibited. See Ind. Code § 27-4-1-4.5.

One such practice is failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under policies. See Ind. Code § 27-4-1-4.5(2).

Prompt, Fair and Equitable Settlement of Claim

Under Indiana law, certain practices committed by an insurer with respect to claims, if performed with such frequency as to indicate a general business practice, are defined as unfair and deceptive practices and are prohibited. See Ind. Code § 27-4-1-4.5.

One such practice is failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under policies. See Ind. Code § 27-4-1-4.5(3).

Another such practice is failing to affirm or deny coverage of claims within a reasonable time after proof of loss requirements under the policy have been completed and submitted by the insured. See Ind. Code § 27-4-1-4.5(5).

Another such practice is not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear. See Ind. Code § 27-4-1-4.5(6).
27-4-1-4.5 Enumeration of unfair claim settlement practices

(1) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue.

(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 based upon all available information.

(5) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed.

(6) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.

(7) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds.

(8) Attempting to settle a claim for less than the amount to which a reasonable individual would have believed the individual was entitled by reference to written or printed advertising material accompanying or made part of an application.

(9) Attempting to settle claims on the basis of an application that was altered without notice to or knowledge or consent of the insured.

(10) Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which the payments are being made.

(11) Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.
(12) Delaying the investigation or payment of claims by requiring an insured, a claimant, or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information.

(13) Failing to promptly settle claims, where liability has become reasonably clear, under one (1) portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

(14) 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.

(15) In negotiations concerning liability insurance claims, ascribing a percentage of fault to a person seeking to recover from an insured party, in spite of an obvious absence of fault on the part of that person.

(16) The unfair claims settlement practices defined in IC 27-4-1.5.
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Acknowledgment of Claim

Under Iowa law, certain practices committee by an insurer with respect to claims, if performed with such frequency as to indicate a general business practice, are defined as unfair and deceptive practices and are prohibited. See Iowa Code § 507B.4(9).

One such practice is failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under policies. See Iowa Code § 507B.4(9)(b).

Prompt, Fair and Equitable Settlement of Claim

Under Iowa law, certain practices committee by an insurer with respect to claims, if performed with such frequency as to indicate a general business practice, are defined as unfair and deceptive practices and are prohibited. See Iowa Code § 507B.4(9).

One such practice is failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under policies. See Iowa Code § 507B.4(9)(c).

Another such practice is failing to affirm or deny coverage of claims within a reasonable time after proof of loss requirements under the policy have been completed and submitted by the insured. See Iowa Code § 507B.4(9)(e).

Another such practice is not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear. See Iowa Code § 507B.4(9)(f).
507B.4. Unfair methods of competition and unfair or deceptive acts or practices defined

The following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance: . . .

9. Unfair claim settlement practices. Committing or performing with such frequency as to indicate a general business practice any of the following:

a. Misrepresenting pertinent facts or insurance policy provisions relating to coverages of issue.

b. Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.

c. Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.

d. Refusing to pay claims without conducting a reasonable investigation based upon all available information.

e. Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed.

f. Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear, or failing to include interest on the payment of claims when required under subsection 15 or section 511.38.

g. Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds.

h. Attempting to settle a claim for less than the amount to which a reasonable person would have believed the person was entitled by reference to written or printed advertising material accompanying or made part of an application.
i. Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of the insured.

j. Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made.

k. Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

l. Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information.

m. 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.

n. 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.

o. Failing to comply with the procedures for auditing claims submitted by health care providers as set forth by rule of the commissioner. However, this paragraph shall have no applicability to liability insurance, workers' compensation or similar insurance, automobile or homeowners' medical payment insurance, disability income, or long-term care insurance.
Acknowledgment of Claim

Under Kansas law, certain practices committed by an insurer with respect to claims, if committed flagrantly and in conscious disregard of relevant provisions, or if performed with such frequency as to indicate a general business practice, are defined as unfair and deceptive practices and are prohibited. See Kan. Stat. Ann. § 40-2409(9).

One such practice is failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under policies. See Kan. Stat. Ann. § 40-2409(9)(b).

Prompt, Fair and Equitable Settlement of Claim

Under Kansas law, certain practices committed by an insurer with respect to claims, if performed with such frequency as to indicate a general business practice, are defined as unfair and deceptive practices and are prohibited. See Kan. Stat. Ann. § 40-2409(9).

One such practice is failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under policies. See Kan. Stat. Ann. § 40-2409(9)(c).

Another such practice is failing to affirm or deny coverage of claims within a reasonable time after proof of loss requirements under the policy have been completed and submitted by the insured. See Kan. Stat. Ann. § 40-2409(9)(e).

Another such practice is not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear. See Kan. Stat. Ann. § 40-2409(9)(f).
40-2404. Unfair methods of competition or unfair and deceptive acts or practices; title insurance agents, requirements; disclosure of nonpublic personal information; rules and regulations.

The following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance: . . .

(9) Unfair claim settlement practices. It is an unfair claim settlement practice if any of the following or any rules and regulations pertaining thereto are: (A) Committed flagrantly and in conscious disregard of such provisions, or (B) committed with such frequency as to indicate a general business practice.

(a) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

(b) failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

(c) failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

(d) refusing to pay claims without conducting a reasonable investigation based upon all available information;

(e) failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(f) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;

(g) compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds;

(h) attempting to settle a claim for less than the amount to which a reasonable person would have believed that such person was entitled by reference to written or printed advertising material accompanying or made part of an application;
(i) attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of the insured;

(j) making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made;

(k) making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

(l) delaying the investigation or payment of claims by requiring an insured, claimant or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(m) 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; or

(n) 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.
Acknowledgment of Claim

Under Kentucky law, insurers must acknowledge the receipt of a notification of claim within 15 days after receiving it, unless payment is made within such period of time. See 806 Ky. Admin. Regs. 12:095, § 5(1).

Furthermore, insurers must promptly provide all necessary claims forms, instructions, and reasonable assistance to first-party claimants so they can comply with the policy conditions and insurer’s reasonable requirements. Compliance with this subsection constitutes compliance with the preceding paragraph. See 806 Ky. Admin. Regs. 12:095, § 5(4).

Also, insurers must make an appropriate reply within 15 days on all other pertinent communications from a claimant which reasonably suggest that a response is expected. See 806 Ky. Admin. Regs. 12:095, § 5(3).

Prompt, Fair and Equitable Settlement of Claim

Under Kentucky law, insurers must affirm or deny liability on claims within a reasonable time and shall offer any payment due within 30 calendar days of receipt of proof of loss. See 806 Ky. Admin. Regs. 12:095, § 6(1)(a).

If more time is needed to determine whether a first-party claim should be accepted or denied, the insurer must notify the first-party claimant within 30 calendar days after receipt of proofs of loss, stating reasons more time is needed. See 806 Ky. Admin. Regs. 12:095, § 6(2)(a).

If the investigation remains incomplete, the insurer must send the first-party claimant a letter 45 days from the date of the initial notification and every 45 days thereafter, setting forth the reasons additional time is needed for investigation. See 806 Ky. Admin. Regs. 12:095, § 6(2)(b).
806 KAR 12:095. Unfair claims settlement practices for property and casualty insurance.

Section 1. Definitions.

(1) "Agent" means any person authorized to represent an insurer with respect to a claim;

(2) "Claimant" means either a first party claimant, a third-party claimant, or both and includes the claimant's designated legal representative, such as an administrator, executor, guardian, or similar person, and includes a member of the insured's immediate family designated by the claimant;

(3) "Claim file" means any retrievable electronic file, paper file, or both;

(4) "Commissioner" is defined in KRS 304.1-050(1);

(5) "Days" means any day, Monday through Friday, except holidays;

(6) "First party claimant" means a person asserting a right to payment under an insurance policy, certificate, or contract arising out of the occurrence of the contingency or loss covered by the policy, certificate, or contract;

(7) "Insurer" is defined by KRS 304.1-040;

(8) "Investigation" means all activities of an insurer related to the determination of liabilities under coverages afforded by a policy, certificate, or contract;

(9) "Local market area" means a reasonable distance surrounding the area where a motor vehicle is principally garaged, or the usual location of the article covered by the policy. This area shall not be limited to the geographic boundaries of the Commonwealth;

(10) "Notification of claim" means any notification, whether in writing or by other means acceptable under the terms of the policy, certificate, or contract, to an insurer or its agent, by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim;

(11) "Policy", or "certificate", or "contract" means any contract of insurance or indemnity, except for:
    (a) Fidelity, suretyship, or boiler and machinery insurance; or
    (b) A contract of workers' compensation insurance unless it satisfies the requirements of Section 2 of this administrative regulation.
(12) "Replacement crash part" means sheet metal or plastic parts which generally constitute the exterior of a motor vehicle, including inner and outer panels; and

(13) "Third party claimant" means any person asserting a claim against any person under a policy, contract, or certificate of an insurer.

Section 2. Scope and Purpose of This Administrative Regulation. (1) This administrative regulation establishes minimum standards for the investigation and disposition of property and casualty insurance claims arising under policies, certificates, and contracts. This administrative regulation shall not cover claims involving fidelity, suretyship, or boiler and machinery insurance. This administrative regulation shall not cover claims involving workers' compensation if those question arise under KRS Chapter 342 since those questions shall be resolved by workers' compensation administrative law judges or arbitrators, pursuant to KRS 342.325. This administrative regulation shall apply to claims for unearned premium refunds under workers' compensation policies since workers' compensation administrative law judges or arbitrators do not have jurisdiction over those claims. This administrative regulation establishes procedures and practices which constitute unfair claims settlement practices.

(2) Statement of enforcement policy.

If complaints are filed with the commissioner, the commissioner shall note violations of this administrative regulation after the insurer or agent has been given an opportunity to pay the claim and any interest thereon.

(3) This administrative regulation establishes standards for the commissioner in investigations, examinations, and administrative adjudication and appeals therefrom. A violation of this administrative regulation shall be found only by the commissioner. This administrative regulation shall not create or imply a private cause of action for violation of this administrative regulation.

Section 3. File and Record Documentation. Each insurer's claim files for policies, certificates, or contracts are subject to examination by the commissioner or the commissioner's designees. To aid in an examination:

(1) The insurer shall maintain claim data that are accessible and retrievable for examination. An insurer shall be able to provide the claim number, line of coverage, date of loss and date of payment of the claim, and date of denial of or date closed without payment. This data shall be available for all open and closed files for the current year and the five (5) preceding years.

(2) The insurer shall maintain documentation in each claim file to permit reconstruction of the insurer's activities relative to each claim.

(3) The insurer shall note each relevant document within the claim file as to date received, date processed, or date mailed.

(4) If an insurer does not maintain hard copy files, claim files shall be accessible from a computer terminal available to examiners or micrographics and be capable of duplication to legible hard copy.

Section 4. Misrepresentation of Policy Provisions. (1) Insurers and agents shall not misrepresent or conceal from first party claimants any pertinent benefits, coverages, or other provisions of any insurance policy or insurance contract if the benefits, coverages, or other provisions are pertinent to a claim, pursuant to KRS 304.12-230(1).

(2) Insurers shall not deny a claim on the basis of failure to exhibit property unless there is documentation in the claim file of breach of the policy provisions.
(3) Insurers shall not deny a claim based upon the failure of a first party claimant to give written notice of loss within a specified time limit unless written notice of loss is a written condition in the policy, certificate, or contract and the first-party claimant's failure to give written notice after being requested to do so is so unreasonable as to constitute a breach of the first-party claimant's duty to cooperate with the insurer.

(4) Insurers shall not indicate to a first party claimant on a payment draft, check, or in an accompanying letter that payment is "final" or "a release" of any claim unless:

(a) The policy limit has been paid; or

(b) There has been a compromise settlement agreed to by the first party claimant and the insurer as to coverage and amount payable under the policy, certificate, or contract.

(5) Insurers shall not issue checks or drafts in partial settlement of a loss or claim under a specific coverage which contain language which releases the insurer or its insured from total liability.

Section 5. Failure to Acknowledge Pertinent Communications. (1) Every insurer, upon receiving notification of a claim shall, within fifteen (15) days, acknowledge the receipt of the notice unless payment is made within that period of time. If an acknowledgement is made by means other than writing, an appropriate notation of the acknowledgement shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer.

(2) If an insurer receives an inquiry from the Department of Insurance respecting a claim, the insurer shall, within fifteen (15) days of receipt of the inquiry, furnish the Department of Insurance with an adequate response to the inquiry in duplicate.

(3) The insurer shall make an appropriate reply within fifteen (15) days on all other pertinent communications from a claimant which reasonably suggest that a response is expected.

(4) Every insurer, upon receiving notification of claim, shall promptly provide necessary claim forms, instructions, and reasonable assistance to first party claimants so that they can comply with the policy conditions and the insurer's reasonable requirements. Compliance with this subsection within fifteen (15) days of notification of a claim shall constitute compliance with subsection (1) of this section.

Section 6. Standards for Prompt, Fair, and Equitable Settlements Applicable to All Insurers. (1)(a) Pursuant to KRS 304.12-230(5), an insurer shall, pursuant to KRS 304.12-235(1), affirm or deny any liability on claims within a reasonable time and shall offer any payment due within thirty (30) calendar days of receipt of due proof of loss. If claims involve multiple coverages, payments which are not in dispute shall be tendered within thirty (30) calendar days of receipt of due proof of loss.

(b) If there is a reasonable basis supported by specific information available for review by the commissioner that a claimant has fraudulently caused or contributed to the loss, the insurer shall:

1. Be relieved from the requirements of this subsection; and

2. Advise the claimant of the acceptance or denial of the claim within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.

(2)(a) If the insurer needs more time to determine whether a first party claim should be accepted or
(b) If the investigation remains incomplete, the insurer shall, forty-five (45) calendar days from the date of the initial notification and every forty-five (45) calendar days thereafter, send to the first party claimant a letter stating the reasons additional time is needed for investigation.

(3) Insurers shall not fail to settle first party claims on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions.

(4) Insurers shall not continue negotiations for settlement of a claim directly with a first party claimant who is not legally represented if the first party claimant’s rights may be affected by a statute of limitations or a time limit in a policy, certificate, or contract, unless the insurer has given the first party claimant written notice of the limitation. The notice shall be given to the first party claimant at least thirty (30) calendar days before the date on which the time limit expires.

(5) Insurers shall 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 given period of time unless the statement is given for the purpose of notifying the third-party claimant of the provision of a statute of limitations.

(6) Subject to subsection (1)(a) of this section relating to first party claims, insurers shall affirm or deny liability on claims within a reasonable time and shall tender payment within thirty (30) days of affirmation of liability, if the amount of the claim is determined and not in dispute. If claims involve multiple coverages, and if the payee is known, payments which are not in dispute shall be tendered within thirty (30) calendar days.

(7) Insurers shall not request or require any insured to submit to a polygraph examination unless authorized under the applicable policy, certificate, contract, or applicable law.
Acknowledgment of Claim

Under Louisiana law, certain practices committed by an insurer with respect to claims, if performed with such frequency as to indicate a general business practice, are defined as unfair and deceptive practices and are prohibited. See La. Rev. Stat. Ann. § 22:1214(14).

One such practice is failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under policies. See La. Rev. Stat. Ann. § 22:1214(14) (b).

Prompt, Fair and Equitable Settlement of Claim

Under Louisiana law, certain practices committed by an insurer with respect to claims, if performed with such frequency as to indicate a general business practice, are defined as unfair and deceptive practices and are prohibited. See La. Rev. Stat. Ann. § 22:1214(14).


Another such practice is failing to affirm or deny coverage of claims within a reasonable time after proof of loss requirements under the policy have been completed and submitted by the insured. See La. Rev. Stat. Ann. § 22:1214(14)(e).

Another such practice is not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear. See La. Rev. Stat. Ann. § 22:1214(14)(f).
§ 1214. Methods, acts, and practices which are defined herein as unfair or deceptive

The following are declared to be unfair methods of competition and unfair or deceptive acts or practices in the business of insurance: . . .

(14) Unfair claims settlement practices. Committing or performing with such frequency as to indicate a general business practice any of the following:

(a) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue.

(b) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.

(c) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.

(d) Refusing to pay claims without conducting a reasonable investigation based upon all available information.

(e) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed.

(f) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.

(g) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds.

(h) Attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application.
(i) Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of, the insured.

(j) Making claims payments to insureds or beneficiaries not accompanied by statement setting forth the coverage under which the payments are being made.

(k) Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

(l) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information.

(m) 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.

(n) 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.

(o) Failing to provide forms necessary to present claims within fifteen calendar days of a request with reasonable explanations regarding their use, if the insurer maintains the forms for that purpose.
Acknowledgment of Claim

Under Maine law, certain practices committed by an insurer with respect to claims, if performed with such frequency as to indicate a general business practice, are defined as unfair and deceptive practices and are prohibited. See Me. Rev. Stat. Ann. tit. 24-A § 2164-D.

One such practice is failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under policies. See Me. Rev. Stat. Ann. tit. 24-A § 2164-D(3)(B).

Prompt, Fair and Equitable Settlement of Claim

Under Maine law, certain practices committed by an insurer with respect to claims, if performed with such frequency as to indicate a general business practice, are defined as unfair and deceptive practices and are prohibited. See Me. Rev. Stat. Ann. tit. 24-A § 2164-D.

Another such practice is failing to affirm or deny coverage of claims within a reasonable time after having completed its investigation related to a claim. See Me. Rev. Stat. Ann. tit. 24-A § 2164-D(3)(F).

Another such practice is not attempting in good faith to resolve claims. See Me. Rev. Stat. Ann. tit. 24-A § 2164-D(5).
§ 2164-D. Unfair claims practices

1. Definition. As used in this section, “insurer” means any person, reciprocal exchange, Lloyd’s insurer, fraternal benefit society and any other legal entity engaged in the business of insurance, including, but not limited to, producers, adjusters and 3rd-party administrators. “Insurer” also means nonprofit hospital or medical service organizations, as described in Title 24, section 2301.

2. Prohibited activities. It is an unfair claims practice for any domestic, foreign or alien insurer transacting business in this State to commit any act under subsection 3 if:

   A. It is committed in conscious disregard of this section and any rules adopted under this section; or

   B. It has been committed with such frequency as to indicate a general business practice to engage in that type of conduct.

3. Unfair practices. Any of the following acts by an insurer, if committed in violation of subsection 2, constitutes an unfair claims practice:

   A. Knowingly misrepresenting to claimants and insureds relevant facts or policy provisions related to coverages at issue;

   B. Failing to acknowledge with reasonable promptness pertinent written communications with respect to claims arising under its policies;

   C. Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies;

   D. Failing to develop and maintain documented claim files supporting decisions made regarding liability;

   E. Refusing to pay claims without conducting a reasonable investigation;

   F. Failing to affirm coverage or deny coverage, reserving any appropriate defenses, within a reasonable time after having completed its investigation related to a claim;

   G. Attempting to settle or settling claims on the basis of an application that was materially altered without notice to, or knowledge or consent of, the insured;

   H. Making claim payments to an insured or beneficiary without indicating the coverage under which each payment is being made;
I. Unreasonably delaying the investigation or payment of claims by requiring both a formal proof of loss and subsequent verification when subsequent verification would result in duplication of information appearing in the formal proof of loss;

J. Failing, in the case of claims denials or offers of compromise settlement, to promptly provide an accurate written explanation of the basis for those actions;

K. Failing to provide forms, accompanied by reasonable explanations for their use, necessary to present claims within 15 calendar days of such a request. This paragraph does not apply when there is an extraordinary loss or series of losses resulting from a catastrophe as determined by the superintendent; or

L. Failing to adopt and implement reasonable standards to ensure that the repairs of a repairer owned by or required to be used by the insurer are performed in a professional manner.

4. Compelling insureds to institute suits. It is an unfair claims practice for any domestic, foreign or alien insurer transacting business in this State to compel insureds to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them with such frequency as to indicate a general business practice; except that this provision does not apply when the insurer has a reasonable basis to contest liability or dispute the amount of any damages or the extent of any injuries claimed.

5. Resolution of claims. It is an unfair claims practice for any domestic, foreign or alien insurer transacting business in this State to fail to deal with insureds in good faith to resolve claims made against policies of insureds without just cause and with such frequency as to indicate a general business practice.

6. Chapter 56-A. The superintendent shall ensure that the provisions of chapter 56-A and any rules adopted pursuant to that chapter are enforced consistent with this section.

7. Rules. The superintendent may adopt rules necessary to carry out the provisions of this section. Rules adopted pursuant to this section are major substantive rules as defined in Title 5, chapter 375, subchapter II-A.

8. Private action. This section may not be construed as abridging an insurer’s duty to its insured or altering policy provisions. This section may not be construed to create or imply a private cause of action for violation of this section.

9. Applicability. This section does not apply to claims involving workers’ compensation, medical malpractice, fidelity, suretyship or boiler and machinery insurance.
**MARYLAND**

**Acknowledgment of Claim**

Under Maryland law, any single act or omission by an insurer isn’t by itself a violation. However, certain claims settlement practices, when committed with such frequency as to indicate a general business practice, are considered unfair and are prohibited. See Md. Regs. Code tit. 31, § 15.07.03(B).

One such example is an insurer failing to acknowledge the receipt of a notification of claim within **15 working days** after receiving it, unless payment is made within such period of time. See Md. Regs. Code tit. 31, § 15.07.03(B)(10).

Another such example is an insurer failing to provide appropriate replies to claimants within **15 working days** of receiving written communications from claimants which suggest a response is expected. See Md. Regs. Code tit. 31, § 15.07.03(B)(15).

**Prompt, Fair and Equitable Settlement of Claim**

Under Maryland law, any single act or omission by an insurer isn’t by itself a violation. However, certain claims settlement practices, when committed with such frequency as to indicate a general business practice, are considered unfair and are prohibited. See Md. Regs. Code tit. 31, § 15.07.03(B).

One such example is an insurer failing to affirm or deny coverage of claims within **15 working days** after receiving properly completed claims forms or other proofs of loss. See Md. Regs. Code tit 31, § 15.07.03(B)(12).

However, if an insurer has not competed its investigation of a first-party claim within **45 days** of notification, the insurer shall promptly notify the first-party claimant, in writing, of the actual reason that additional time is necessary to complete the investigation. Notice must be sent to the first-party claimant after each additional **45 day** period until the insurer either affirms or denies coverage and damages. See Md. Regs. Code tit 31, § 15.07.04(B).
.03 Unfair Claim Settlement Practices.

A. A prohibited unfair claim settlement practice occurs if an insurer commits one or more of the following acts:

(1) Misrepresents pertinent facts or policy provisions relating to the claim at issue. For the purposes of this regulation, misrepresentation includes, but is not limited to, the following acts:

   (a) Providing incomplete or misleading disclosure of pertinent facts or policy provisions relating to the claim at issue;

   (b) Concealing from a first-party claimant benefits, coverages, or other provisions of a policy when these benefits, coverages, or other provisions are pertinent to the claim at issue;

   (c) Failing, upon written request, to disclose to a first-party claimant all benefits, coverages, or other provisions of an insurance policy under which a claim is presented;

   (d) Except when there is a time limit specified in the policy or provided by law, making oral or written statements to any claimant that:

      (i) There is a requirement that the claimant give written notice of loss or proof of loss within a specified time, and

      (ii) The company is relieved of its obligations under the policy if the time limit is not complied with;

   (e) Making oral or written statements to any claimant that there is a requirement that the claimant sign a release that extends beyond the subject matter that gave rise to the claim payment; or

   (f) Issuing a check or draft in partial settlement of a loss or claim under a specific coverage or coverages, which check or draft contains language releasing the insurer or its insured from their total liability.

(2) Attempts to settle a claim on the basis of an application which has been altered without notice to, or the knowledge or consent of, the insured. An insurer may not be found to have violated this regulation unless the:

   (a) Insurer knew or had reason to know of the alteration; and

   (b) Alteration is material to settlement of the claim at issue.

(3) Refuses to pay a claim for an arbitrary or capricious reason based on all available information.

(4) Fails to include, in any claim paid to an insured or beneficiary, a statement or other identification setting forth the specific policy coverage under which the payment is made.
(5) Fails to make a good faith attempt to settle a claim promptly under one portion of a policy, whenever liability is reasonably clear, in order to influence settlements under other portions of the policy.

(6) Fails to promptly provide a reasonable explanation of the basis for denial of a claim when requested to do so.

B. A prohibited unfair claim settlement practice occurs if an insurer commits one or more of the following acts with such frequency as to indicate a general business practice:

1. Misrepresents pertinent facts or policy provisions relating to the coverages at issue. For the purposes of this regulation, misrepresentation includes, but is not limited to, the following acts:
   a. Providing incomplete or misleading disclosure of pertinent facts or policy provisions related to the coverages at issue;
   b. Concealing from a first-party claimant benefits, coverages, or other provisions of a policy when these benefits, coverages, or other provisions are pertinent to the claim at issue;
   c. Failing, upon written request, to disclose to a first-party claimant all benefits, coverages, or other provisions of an insurance policy under which a claim is presented;
   d. Except when there is a time limit specified in the policy or provided by law, making oral or written statements to any claimant that:
      i. There is a requirement that the claimant give written notice of loss or proof of loss within a specified time, and
      ii. The company is relieved of its obligations under the policy if the time limit is not complied with;
   e. Making oral or written statements by any claimant that there is a requirement that the claimant sign a release that extends beyond the subject matter that gave rise to the claim payment; or
   f. Issuing a check or draft in partial settlement of a loss or claim under a specific coverage or coverages, which check or draft contains language releasing the insurer or its insured from total liability.

2. Fails to include, in claims paid to insureds or beneficiaries, statements or other identification setting forth the specific policy coverage under which the payments are made.

3. Fails to promptly provide to any claimants reasonable explanations of the basis for denial of claims or the offer of compromise settlements.

4. Fails to adopt and implement reasonable standards for the prompt investigation of claims arising under policies.

5. Refuses to pay claims without conducting reasonable investigations based on all available information.

6. Fails to make good faith attempts to settle claims promptly, fairly, or equitably once liability has become reasonably clear.

7. Compels insureds to institute litigation to recover amounts due them under policies by offering substantially less than the amounts ultimately recovered in actions brought by the insureds.
(8) Attempts to settle claims on the basis of applications which have been altered without notice to, or the knowledge or consent of, insureds. An insurer may not be found to have violated this regulation unless the:

(a) Insurer knew or had reason to know of the alterations; and
(b) Alterations are material to settlement of the claims at issue.

(9) Fails to make good faith attempts to settle claims promptly under one portion of a policy, whenever liability is reasonably clear, in order to influence settlements under other portions of the policy.

(10) Fails, upon receipt of notification of claims, to acknowledge receipt of the notification within 15 working days, unless payment is made within that period of time.

(11) Fails, upon receipt of inquiries from the Maryland Insurance Administration regarding claims, to furnish the Maryland Insurance Administration with adequate responses to the inquiries within 15 working days.

(12) Fails to affirm or deny coverage of claims within 15 working days after receiving properly completed claim forms or other proofs of loss, unless the provisions of Regulation .04B of this chapter apply or unless there is a time limit specified in the policy.

(13) Refuses to fully satisfy claims for arbitrary or capricious reasons.

(14) Refuses or unreasonably delays payment to claimants of amounts due them when coverage, liability, and amount of damages are reasonably clear.

(15) Fails to provide appropriate replies to claimants or their representatives within 15 working days of receiving written communications from claimants or their representatives which suggest that a response is expected.

C. The provision of any claim forms required by the insurer, instructions, and reasonable assistance, in order that first-party claimants can comply with policy conditions and the insurer’s reasonable requirements for filing claims, shall satisfy the requirement that insurers acknowledge receipt of notification of claims within 15 working days.

.04 Standards for Prompt Investigation of Claims.

A. Insurers shall, for at least 3 years, make available for inspection by the Maryland Insurance Administration records of denials of claims and supporting documentation.

B. If an insurer has not completed its investigation of a first party claim within 45 days of notification, the insurer shall promptly notify the first-party claimant, in writing, of the actual reason that additional time is necessary to complete the investigation. Notice shall be sent to the first-party claimant after each additional 45-day period until the insurer either affirms or denies coverage and damages.

C. In any case in which a first-party claimant is neither an attorney nor represented by an attorney, the insurer shall, upon receipt of a written claim, inform that claimant in writing that there may be an applicable statute of limitations which may bar that claimant’s rights in the future.

D. An insurer that denies a claim on the grounds of a specific policy provision, condition, or exclusion shall advise the claimant as to the provision, condition, or exclusion on which the denial is based.

E. When there is a reasonable basis, supported by specific information available for review by the Commissioner, that the first-party claimant has fraudulently caused or contributed to the loss, the insurer is relieved of the requirement contained in B and C of this regulation that the insurer state the reason that more time is required.
F. If a claim is denied for reasons other than those described in §D or E of this regulation, an appropriate notation shall be made in the claim file of the insurer.
Acknowledgment of Claim

Under Massachusetts law, certain practices committed by an insurer with respect to claims, if performed with such frequency as to indicate a general business practice, are defined as unfair business practices and are prohibited. See Mass. Gen. Laws ch. 176D, § 3(9).

One such practice is failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under policies. See Mass. Gen. Laws ch. 176D, § 3(9)(b).

Prompt, Fair and Equitable Settlement of Claim

Under Massachusetts law, certain practices committed by an insurer with respect to claims, if performed with such frequency as to indicate a general business practice, are defined as unfair business practices and are prohibited. See Mass. Gen. Laws ch. 176D, § 3(9).

One such practice is failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under policies. See Mass. Gen. Laws ch. 176D, § 3(9)(c).

Another such practice is failing to affirm or deny coverage of claims within a reasonable time after proof of loss requirements under the policy have been completed and submitted by the insured. See Mass. Gen. Laws ch. 176D, § 3(9)(e).

Another such practice is not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear. See Mass. Gen. Laws ch. 176D, § 3(9)(f).
§ 3. Unfair methods of competition and unfair or deceptive acts or practices

The following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(1) Misrepresentations and false advertising of insurance policies: making, issuing, circulating, or causing to be made, issued or circulated, any estimate, illustration, circular or statement which:

(a) Misrepresents the benefits, advantages, conditions, or terms of any insurance policy;

(b) Misrepresents the dividends or shares of the surplus to be received on any insurance policy;

(c) Makes any false or misleading statements as to the dividends or share or surplus previously paid on any insurance policy;

(d) Misleads or misrepresents the financial condition of any person or the legal reserve system upon which any life insurer operates;

(e) Uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof;

(f) Misrepresents for the purpose of inducing or tending to induce the lapse, forfeiture, exchange, conversion, or surrender of any insurance policy;

(g) Misrepresents for the purpose of effecting a pledge or assignment of or effecting a loan against any insurance policy; or

(h) Misrepresents any insurance policy as being shares of stock.

(2) False information and advertising generally: making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or
placed before the public, in newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster or over any radio or television station, or in any other way, an advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading.

(3) Defamation: making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting or encouraging the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article or literature which is false, or maliciously critical of or derogatory to the financial condition of any person, and which is calculated to injure such person.

(4) Boycott, coercion and intimidation: entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance; any refusal by a nonprofit hospital service corporation, medical service corporation, insurance or health maintenance organization to negotiate, contract or affiliate with a health care facility or provider because of such facility's or provider's contracts or affiliations with any other nonprofit hospital service corporation, medical service corporation, insurance company or health maintenance organization; or any nonprofit hospital service corporation, medical service corporation, insurance company or health maintenance organization establishing the price to be paid to any health care facility or provider at a level equal to the lowest price paid to such facility or provider under a contract with any other nonprofit hospital service corporation, medical service corporation, insurance company, health maintenance organization or government payor.

(5) False statements and entries: (a) knowingly filing with any supervisory or other public official, or knowingly making, publishing, disseminating, circulating or delivering to any person, or placing before the public, or knowingly causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false material statement of fact as to the financial condition of a person; or (b) knowingly making any false entry of a material fact in any book, report or statement of any person or knowingly omitting to make a true entry of any material fact pertaining to the business of such person in any book, report or statement of such person.

(6) Stock operations and advisory board contracts: issuing or delivering or permitting agents, officers or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any common-law corporation, securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insurance.

(7) Unfair discrimination: (a) making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract; or (b) making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever.

(8) Rebates: Except as otherwise expressly provided by law, knowingly permitting or offering to make or
making any insurance contract, including but not limited to a contract for life insurance, life annuity or accident and health insurance, or agreement as to such contract other than as plainly expressed in the insurance contract issued thereon, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to such insurance or annuity any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract; or giving, or selling, or purchasing or offering to give, sell, or purchase as inducement to such insurance contract, or annuity or in connection therewith, any stocks, bonds, or other securities of any insurance company or other corporation, association, or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract.

Nothing in clauses (7) or (8) of this subsection shall be construed as including within the definition of discrimination or rebates any of the following practices:—(i) in the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided that any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders; (ii) in the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payment directly to an office of the insurer in the amount which fairly represents the saving in collection expenses; (iii) readjustment of the rate of premium for a group insurance policy based on the loss or expense experienced thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year.

(9) Unfair claim settlement practices: An unfair claim settlement practice shall consist of any of the following acts or omissions:

(a) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

(b) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

(c) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

(d) Refusing to pay claims without conducting a reasonable investigation based upon all available information;

(e) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(f) Failing to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;
(g) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds;

(h) Attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application;

(i) Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of the insured;

(j) Making claims payments to insured or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made;

(k) Making known to insured or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements of compromises less than the amount awarded in arbitration;

(l) Delaying the investigation or payment of claims by requiring that an insured or claimant, or the physician of either, submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(m) Failing to settle claims promptly, 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; or

(n) Failing to provide promptly 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.

(10) Failure to maintain complaint handling procedures; failure of any person to maintain a complete record of all of the complaints which it has received since the date of its last examination, which record shall indicate in such form and detail as the commissioner may from time to time prescribe, the total number of complaints, their classification by line of insurance, and the nature, disposition, and time of processing of each complaint. For purposes of this subsection, "complaint" shall mean any written communication primarily expressing a grievance. Agents, brokers and adjusters shall maintain any written communications received by them which express a grievance for a period of two years from receipt, with a record of their disposition, which shall be available for examination by the commissioner at any time.

(11) Misrepresentation in insurance applications: making false or fraudulent statements or representations on or relative to an application for an insurance policy, for the purpose of obtaining a
fee, commission, money, or other benefit from any insurers, agent, broker, or individual.

(12) Any violation of sections ninety-five, two B, one hundred eighty-one, one hundred eighty-two, one hundred eighty-three, one hundred eighty-seven B, one hundred eighty-seven C, one hundred eighty-seven D, one hundred eighty-nine, one hundred ninety-three E, or one hundred ninety-three K of chapter one hundred seventy-five.
MICHIGAN

Acknowledgment of Claim

Under Michigan law, certain practices committed by an insurer with respect to claims, if they constitute a course of conduct indicating a persistent tendency, are defined as unfair and deceptive practices and are prohibited. See Mich. Comp. Laws § 500.2026(1).

One such practice is failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under policies. See Mich. Comp. Laws § 500.2026(1)(b).

An insurer shall specify in writing the materials which constitute a satisfactory proof of loss not later than 30 days after receipt of claim, unless the claim is settled within the 30 days. See Mich. Comp. Laws § 500.2006(3).

Prompt, Fair and Equitable Settlement of Claims

Under Michigan law, certain practices committed by an insurer with respect to claims, if they constitute a course of conduct indicating a persistent tendency, are defined as unfair and deceptive practices and are prohibited. See Mich. Comp. Laws § 500.2026(1).

One such practice is failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under policies. See Mich. Comp. Laws § 500.2026(1)(c).

Another such practice is failing to affirm or deny coverage of claims within a reasonable time after proof of loss requirements under the policy have been completed and submitted by the insured. See Mich. Comp. Laws § 500.2026(1)(e).

Another such practice is not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear. See Mich. Comp. Laws § 500.2026(1)(f).
500.2026. Course of conduct; complaints

Sec. 2026.

(1) Unfair methods of competition and unfair or deceptive acts or practices in the business of insurance, other than isolated incidents, are a course of conduct indicating a persistent tendency to engage in that type of conduct and include:

(a) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue.

(b) Failing to acknowledge promptly or to act reasonably and promptly upon communications with respect to claims arising under insurance policies.

(c) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.

(d) Refusing to pay claims without conducting a reasonable investigation based upon the available information.

(e) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed.

(f) Failing to attempt in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.

(g) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts due the insureds.

(h) Attempting to settle a claim for less than the amount to which a reasonable person would believe the claimant was entitled, by reference to written or printed advertising material accompanying or made part of an application.

(i) Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of, the insured.

(j) Making a claims payment to a policyholder or beneficiary omitting the coverage under which each payment is being made.

(k) Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

(l) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring subsequent submission of formal proof of loss forms, seeking solely the duplication of a verification.
(m) 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.

(n) 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.

(2) The failure of a person to maintain a complete record of all the complaints of its insureds which it has received since the date of the last examination is an unfair method of competition and unfair or deceptive act or practice in the business of insurance. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition thereof, and the time it took to process each complaint. For purposes of this subsection, "complaint" means a written communication primarily expressing an allegation of acts which would constitute violation of this chapter. If a complaint relating to an insurer is received by an agent of the insurer, the agent shall promptly forward the complaint to the insurer unless the agent resolves the complaint to the satisfaction of the insured within a reasonable time. An insurer shall not be deemed to have engaged in an unfair method of competition or an unfair or deceptive act or practice in the business of insurance in violation of this chapter because of the failure of an agent who is not also an employee to forward a written complaint as required by this subsection.

500.2006. Timely payment of claims or interest; proof of loss; calculation of interest; exemptions

Sec. 2006. (1) A person must pay on a timely basis to its insured, an individual or entity directly entitled to benefits under its insured's contract of insurance, or a third party tort claimant the benefits provided under the terms of its policy, or, in the alternative, the person must pay to its insured, an individual or entity directly entitled to benefits under its insured's contract of insurance, or a third party tort claimant 12% interest, as provided in subsection (4), on claims not paid on a timely basis. Failure to pay claims on a timely basis or to pay interest on claims as provided in subsection (4) is an unfair trade practice unless the claim is reasonably in dispute.

(2) A person shall not be found to have committed an unfair trade practice under this section if the person is found liable for a claim pursuant to a judgment rendered by a court of law, and the person pays to its insured, individual or entity directly entitled to benefits under its insured's contract of insurance, or third party tort claimant interest as provided in subsection (4).

(3) An insurer shall specify in writing the materials that constitute a satisfactory proof of loss not later than 30 days after receipt of a claim unless the claim is settled within the 30 days. If proof of loss is not supplied as to the entire claim, the amount supported by proof of loss shall be considered paid on a timely basis if paid within 60 days after receipt of proof of loss by the insurer. Any part of the remainder of the claim that is later supported by proof of loss shall be considered paid on a timely basis if paid within 60 days after receipt of the proof of loss by the insurer. If the proof of loss provided by the claimant contains facts that clearly indicate the need for additional medical information by the insurer in order to determine its liability under a policy of life insurance, the claim shall be considered paid on a timely basis if paid within 60 days after receipt of necessary medical information by the insurer. Payment of a claim shall not be untimely during any period in which the insurer is unable to pay the claim when there is no recipient who is legally able to give a valid release for the payment, or where the insurer is unable to determine who is entitled to receive the payment, if the insurer has promptly notified...
the claimant of that inability and has offered in good faith to promptly pay the claim upon
determination of who is entitled to receive the payment . . .
**MINNESOTA**

**Acknowledgment of Claim**

Under Minnesota law, an insurer must acknowledge receipt of a notification of claim from an insured or a claimant within **10 business days** after receiving it. See Minn. Stat. § 72A.201, subdiv. 4(1).

The acknowledgment must include the telephone number of the company representative who can assist the insured or the claimant in providing information and assistance that is reasonable so that the insured or claimant can comply with the policy conditions and insurer’s reasonable requirements. See Minn. Stat. § 72A.201, subdiv. 4(1).

Furthermore, an insurer must **promptly** provide all necessary claim forms and instructions to process the claim unless the claim is settled within **10 business days.** See Minn. Stat. § 72A.201, subdiv. 4(1).

An insurer must also reply within **10 business days** of receipt to all other communications about a claim from an insured or claimant that reasonably indicate a response is requested or needed. See Minn. Stat. § 72A.201, subdiv. 4(2).

**Prompt, Fair and Equitable Settlement of Claims**

Under Minnesota law, an insurer must complete its investigation and inform the insured or claimant of acceptance or denial of a claim within **30 business days** after receipt of notification of the claim unless the investigation cannot reasonably be completed within that time. See Minn. Stat. § 72A.201, subdiv. 4(3)(i).

If the investigation cannot reasonably be completed within that time, the insurer must notify the insured or claimant within **30 business days** after receipt of notification of the claim, stating the reasons why the investigation is not complete and the expected date the investigation will be complete. See Minn. Stat. § 72A.201, subdiv. 4(3)(i).

An insurer must also advise the insured of acceptance or denial of a claim within **60 business days** after receipt of a properly executed proof of loss. See Minn. Stat. § 72A.201, subdiv. 4(11).
72A.201. Regulation of claims practices . . .

Subd. 3. Definitions. For the purposes of this section, the following terms have the meanings given them.

(1) Adjuster or adjusters. "Adjuster" or "adjusters" is as defined in section 72B.02.

(2) Agent. "Agent" means insurance agents or insurance agencies licensed pursuant to sections 60K.30 to 60K.56, and representatives of these agents or agencies.

(3) Claim. "Claim" means a request or demand made with an insurer for the payment of funds or the provision of services under the terms of any policy, certificate, contract of insurance, binder, or other contracts of temporary insurance. The term does not include a claim under a health insurance policy made by a participating provider with an insurer in accordance with the participating provider's service agreement with the insurer which has been filed with the commissioner of commerce prior to its use.

(4) Claim settlement. "Claim settlement" means all activities of an insurer related directly or indirectly to the determination of the extent of liabilities due or potentially due under coverages afforded by the policy, and which result in claim payment, claim acceptance, compromise, or other disposition.

(5) Claimant. "Claimant" means any individual, corporation, association, partnership, or other legal entity asserting a claim against any individual, corporation, association, partnership, or other legal entity which is insured under an insurance policy or insurance contract of an insurer.

(6) Complaint. "Complaint" means a communication primarily expressing a grievance.

(7) Insurance policy. "Insurance policy" means any evidence of coverage issued by an insurer including all policies, contracts, certificates, riders, binders, and endorsements which provide or describe coverage. The term includes any contract issuing coverage under a self-insurance plan, group self-insurance plan, or joint self-insurance employee health plans.

(8) Insured. "Insured" means an individual, corporation, association, partnership, or other legal entity asserting a right to payment under their insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by the policy or contract. The term does not apply to a person who acquires rights under a mortgage.

(9) Insurer. "Insurer" includes any individual, corporation, association, partnership, reciprocal exchange, Lloyds, fraternal benefits society, self-insurer, surplus line insurer, self-insurance administrator, and nonprofit service plans under the jurisdiction of the Department of Commerce.
(10) Investigation. "Investigation" means a reasonable procedure adopted by an insurer to determine whether to accept or reject a claim.

(11) Notification of claim. "Notification of claim" means any communication to an insurer by a claimant or an insured which reasonably apprises the insurer of a claim brought under an insurance contract or policy issued by the insurer. Notification of claim to an agent of the insurer is notice to the insurer.

(12) Proof of loss. "Proof of loss" means the necessary documentation required from the insured to establish entitlement to payment under a policy.

(13) Self-insurance administrator. "Self-insurance administrator" means any vendor of risk management services or entities administering self-insurance plans, licensed pursuant to section 60A.23, subdivision 8.

(14) Self-insured or self-insurer. "Self-insured" or "self-insurer" means any entity authorized pursuant to section 65B.48, subdivision 3; chapter 62H; section 176.181, subdivision 2; Laws of Minnesota 1983, chapter 290, section 171; section 471.617; or section 471.981 and includes any entity which, for a fee, employs the services of vendors of risk management services in the administration of a self-insurance plan as defined by section 60A.23, subdivision 8, clause (2), subclauses (a) and (d).

**Subd. 4. Standards for claim filing and handling.** The following acts by an insurer, an adjuster, a self-insured, or a self-insurance administrator constitute unfair settlement practices:

(1) except for claims made under a health insurance policy, after receiving notification of claim from an insured or a claimant, failing to acknowledge receipt of the notification of the claim within ten business days, and failing to promptly provide all necessary claim forms and instructions to process the claim, unless the claim is settled within ten business days. The acknowledgment must include the telephone number of the company representative who can assist the insured or the claimant in providing information and assistance that is reasonable so that the insured or claimant can comply with the policy conditions and the insurer's reasonable requirements. 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 and dated. An appropriate notation must include at least the following information where the acknowledgment is by telephone or oral contact:

(i) the telephone number called, if any;

(ii) the name of the person making the telephone call or oral contact;

(iii) the name of the person who actually received the telephone call or oral contact;

(iv) the time of the telephone call or oral contact; and

(v) the date of the telephone call or oral contact;
failing to reply, within ten business days of receipt, to all other communications about a claim from an insured or a claimant that reasonably indicate a response is requested or needed;

(iii) unless provided otherwise by clause (ii) or (iii), other law, or in the policy, failing to complete its investigation and inform the insured or claimant of acceptance or denial of a claim within 30 business days after receipt of notification of claim unless the investigation cannot be reasonably completed within that time. In the event that the investigation cannot reasonably be completed within that time, the insurer shall notify the insured or claimant within the time period of the reasons why the investigation is not complete and the expected date the investigation will be complete. For claims made under a health policy the notification of claim must be in writing;

(ii) for claims submitted under a health policy, the insurer must comply with all of the requirements of section 62Q.75;

(iii) for claims submitted under a health policy that are accepted, the insurer must notify the insured or claimant no less than semiannually of the disposition of claims of the insured or claimant. For purposes of this clause, acceptance of a claim means that there is no additional financial liability for the insured or claimant, either because there is a flat co-payment amount specified in the health plan or because there is no co-payment, deductible, or coinsurance owed;

where evidence of suspected fraud is present, the requirement to disclose their reasons for failure to complete the investigation within the time period set forth in clause (3) need not be specific. The insurer must make this evidence available to the Department of Commerce if requested;

(failing to notify an insured who has made a notification of claim of all available benefits or coverages which the insured may be eligible to receive under the terms of a policy and of the documentation which the insured must supply in order to ascertain eligibility;

unless otherwise provided by law or in the policy, requiring an insured to give written notice of loss or proof of loss within a specified time, and thereafter seeking to relieve the insurer of its obligations if the time limit is not complied with, unless the failure to comply with the time limit prejudices the insurer's rights and then only if the insurer gave prior notice to the insured of the potential prejudice;

advising an insured or a claimant not to obtain the services of an attorney or an adjuster, or representing that payment will be delayed if an attorney or an adjuster is retained by the insured or the claimant;

failing to advise in writing an insured or claimant who has filed a notification of claim known to be unresolved, and who has not retained an attorney, of the expiration of a statute of limitations at least 60 days prior to that expiration. For the purposes of this clause, any claim on which the insurer has received no communication from the insured or claimant for a period of two years preceding the expiration of the applicable statute of limitations shall not be considered to be known to be unresolved and notice need not be sent pursuant to this clause;

demanding information which would not affect the settlement of the claim;
(10) unless expressly permitted by law or the policy, refusing to settle a claim of an insured on the basis that the responsibility should be assumed by others;

(11) failing, within 60 business days after receipt of a properly executed proof of loss, to advise the insured of the acceptance or denial of the claim by the insurer. No insurer shall deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to the provision, condition, or exclusion is included in the denial. The denial must be given to the insured in writing with a copy filed in the claim file;

(12) denying or reducing a claim on the basis of an application which was altered or falsified by the agent or insurer without the knowledge of the insured;

(13) failing to notify the insured of the existence of the additional living expense coverage when an insured under a homeowners policy sustains a loss by reason of a covered occurrence and the damage to the dwelling is such that it is not habitable;

(14) failing to inform an insured or a claimant that the insurer will pay for an estimate of repair if the insurer requested the estimate and the insured or claimant had previously submitted two estimates of repair.
Acknowledgment of Claim

Mississippi statutes, like every other state, define what constitutes unfair or deceptive acts or practices in the business of insurance. See Miss. Code Ann. § 83-5-35.

However, there is no relevant statute or regulation requiring an insurer to acknowledge a claim within a specific period of time.

Prompt, Fair and Equitable Settlement of Claims

Mississippi statutes, like every other state, define what constitutes unfair or deceptive acts or practices in the business of insurance. See Miss. Code Ann. § 83-5-35.

However, there is no relevant statute or regulation requiring an insurer to investigate and settle a claim, and report the status of the investigation to the claimant, within a specific period of time.
§ 83-5-35. Unfair competition and practices defined

The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance.

(a) Misrepresentations and false advertising of policy contracts. -- Making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular, or statement misrepresenting the terms of any policy issued or to be issued, or the benefits or advantages promised thereby, or the dividends or share of the surplus to be received thereon; or making any false or misleading statement as to the dividends or share of surplus previously paid on similar policies; or making any misleading representation or any misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates; or using any name or title of any policy or class of policies misrepresenting the true nature thereof; or making any misrepresentation to any policyholder insured in any company for the purpose of inducing or tending to induce such policyholder to lapse, forfeit, or surrender his insurance.

(b) False information and advertising generally. -- Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of insurance, or with respect to any person in the conduct of his insurance business, which is untrue, deceptive, or misleading.

(c) Defamation. -- Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature which is false and maliciously critical of or derogatory to the financial condition of an insurer, and which is calculated to injure any person engaged in the business of insurance.

(d) Boycott, coercion and intimidation. -- Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion, or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.

(e) False financial statements. -- Filing with any supervisory or other public official, or making, publishing, disseminating, circulating, or delivering to any person, or placing before the public, or causing directly or indirectly to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false statement of financial condition of an insurer, with intent to deceive.

Making any false entry in any book, report, or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any
public official to whom such insurer is required by law to report or file, or who has authority by law to examine into its condition or into any of its affairs, or, with like intent, willfully omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report, or statement of such insurer.

(f) **Stock operations and insurance company advisory board contracts.** -- Issuing or delivering, or permitting agents, officers, or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any corporation, or securities, or any special or any insurance company advisory board contracts or other contracts of any kind promising returns and profit as an inducement to insurance.

(g) **Unfair discrimination.** -- (1) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract.

(2) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever.

(h) **Designation of agent, solicitor, or insurer.** -- Requiring as a condition precedent to the purchase or the lending of money upon the security of real or personal property that any insurance covering such property or liability arising from the ownership, maintenance, or use thereof, to be procured by or on behalf of the vendee or by borrower in connection with such purchase or loan, be so procured through any particular person, agent, solicitor, or in any particular insurer.

This section shall not prevent the reasonable exercise by any such vendor or lender of his right to approve or disapprove the insurer selected to underwrite the insurance, and to determine the adequacy of the insurance offered.

(i) Any violation of sections 83-3-33 and 83-3-121, Code of 1972.
Acknowledgment of Claim

Under Missouri law, insurers must acknowledge the receipt of a notification of claim within 10 working days after receiving it, unless payment is made within such period of time. See Mo. Code Regs. Ann. tit. 20, § 100-1.030(1).

Furthermore, insurers must promptly provide all necessary claim forms, instructions, and reasonable assistance so that first-party claimants can comply with policy conditions. Compliance with this paragraph within 10 working days of notification of a claim shall constitute compliance with the above paragraph. See Mo. Code Regs. Ann. tit. 20, § 100-1.030(2).

Also, insurers must make an appropriate reply within 10 working days to all other pertinent communications from a claimant which reasonably suggest that a response is expected. See Mo. Code Regs. Ann. tit. 20, § 100-1.030(2).

Prompt, Fair and Equitable Settlement of Claims

Under Missouri law, every insurer shall complete an investigation of a claim within thirty (30) days after notification of the claim, unless the investigation cannot reasonably be completed within this time. See Mo. Code Regs. Ann. tit. 20, § 100-1.040.

Insurers must advise first-party claimants of the acceptance or denial of the claim within 15 working days after receipt by the insurer of properly executed proofs of loss. A denial must be in writing and include reference to a specific policy provision. See Mo. Code Regs. Ann. tit. 20, § 100-1.050(1)(A).

If more time is needed to determine acceptance or denial, the insurer must notify the first-party claimant within 15 working days after receipt of the proofs of loss, giving reasons more time is needed. See Mo. Code Regs. Ann. tit. 20, § 100-1.050(1)(C).

If the investigation remains incomplete, the insurer must send the claimant a letter 45 days from the time of initial notification and ever 45 days thereafter, setting forth the reasons additional time is needed for investigation. See Mo. Code Regs. Ann. tit. 20, § 100-1.050(1)(C).
20 CSR 100-1.030 Failure to Acknowledge Pertinent Communication

PURPOSE: This rule effectuates or aids in the interpretation of section 375.1007(2), RSMo.

(1) Every insurer, upon receiving notification of claim from any first-party claimant within ten (10) working days, shall acknowledge the receipt of the notification unless payment is made within the period of time. If an acknowledgment is made by means other than writing, an appropriate notation of this acknowledgment shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer.

(2) An appropriate reply shall be made within ten (10) working days on all communications from any claimant which reasonably suggests that a response is expected.

(3) Every insurer, upon receiving notification of claim, promptly shall 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 section within ten (10) working days of notification of a claim shall constitute compliance with section (1) of this rule.

20 CSR 100-1.040 Standards for Prompt Investigation of Claims

PURPOSE: This rule effectuates or aids in the interpretation of section 375.1007(3), RSMo.

Standards for Prompt Investigations of Claims. Every insurer shall complete an investigation of a claim within thirty (30) days after notification of the claim, unless the investigation cannot reasonably be completed within this time.

20 CSR 100-1.050 Standards for Prompt, Fair and Equitable Settlement of Claims

PURPOSE: This rule effectuates or aids in the interpretation of section 375.1007(4), RSMo.

(1) Standards for Prompt, Fair and Equitable Settlements Applicable to All Insurers.
(A) Within fifteen (15) working days after the submission of all forms necessary to establish the nature and extent of any claim, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. No insurer shall deny any claim on the grounds of a specific policy provision, condition or exclusion unless reference to that provision, condition or exclusion is included in the denial. The denial must be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial.

(B) If a claim is denied for reasons other than those described in subsection (1)(A), an appropriate notation shall be made in the claim file of the insurer.

(C) If the insurer needs more time to determine whether a claim should be accepted or denied, it shall so notify the first-party claimant within the time otherwise allotted for acceptance or denial, giving the reasons more time is needed. If the investigation remains incomplete, the insurer, within forty-five (45) days from the date of the initial notification and every forty-five (45) days after, shall send the claimant a letter setting forth the reasons additional time is needed for investigation.

(D) No insurer shall fail to settle any first-party claim on the basis that responsibility for payment should be assumed by others except as otherwise may be provided by policy provisions.

(E) No insurer shall continue negotiations or settlement of any 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 time limit, without giving the claimant written notice that the time limit may be expiring and may affect the claimant’s rights. The notice shall be given to first-party claimants thirty (30) days and to third-party claimants sixty (60) days before the date on which the time limit may expire.

(F) No insurer shall make any statement which indicates that the rights of a third-party claimant may be impaired if a form of release is not completed within a given period of time unless the statement is given for the purpose of notifying the third-party claimant of the provision of a statute of limitations.

(G) All insurers offering cash settlements of first-party long-term disability income claims shall develop a present value calculation of future benefits utilizing contingencies, such as mortality, morbidity and interest rate assumptions, etc., appropriate to the risk. A copy of the amount so calculated shall be given to the insured and signed by him/her at the time a settlement is entered into. A copy of the amount with the calculations also shall be given to the insured at the time the insured is first approached regarding settlement. This acknowledgment of advice of probable value of the contract, together with a copy of the calculations used to arrive at the amount, shall be maintained in the claim file whenever a cash settlement is accepted by the insured. This regulation shall not apply to the settlement of liability insurance claims or structured settlements made in settlement of liability insurance claims. The furnishing of a present value calculation to an insured shall not be construed to imply or impose any liability on the insurer.
(H) Interest at the rate of nine percent (9%) per annum shall be paid on all life insurance policy proceeds upon the death of the insured if the insurer fails to pay the proceeds of the policy within thirty (30) days of submission of proof of death and receipt of all necessary proofs of loss. Payment shall include interest at nine percent (9%) per annum, unless another rate has been agreed upon, from the date of death of the insured until the date the claim is paid.

(2) Standards for Prompt, Fair and Equitable Settlements Applicable to Automobile Insurance. . .
Acknowledgment of Claim

Under Montana law, certain practices committed by an insurer with respect to claims, if performed with such frequency as to indicate a general business practice, are defined as unfair and deceptive practices and are prohibited. See Mont. Code Ann. § 33-18-201.

One such practice is failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under policies. See Mont. Code Ann. § 33-18-201(2).

Prompt, Fair and Equitable Settlement of Claims

Under Montana law, certain practices committed by an insurer with respect to claims, if performed with such frequency as to indicate a general business practice, are defined as unfair and deceptive practices and are prohibited. See Mont. Code Ann. § 33-18-201.

One such practice is failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under policies. See Mont. Code Ann. § 33-18-201(3).

Another such practice is failing to affirm or deny coverage of claims within a reasonable time after proof of loss requirements under the policy have been completed and submitted by the insured. See Mont. Code Ann. § 33-18-201(5).

Another such practice is not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear. See Mont. Code Ann. § 33-18-201(6).
33-18-201. Unfair claim settlement practices prohibited

No person may, with such frequency as to indicate a general business practice, do any of the following:

(1) misrepresent pertinent facts or insurance policy provisions relating to coverages at issue;

(2) fail to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

(3) fail to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

(4) refuse to pay claims without conducting a reasonable investigation based upon all available information;

(5) fail to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(6) neglect to attempt in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear;

(7) compel insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds;

(8) attempt to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application;

(9) attempt to settle claims on the basis of an application which was altered without notice to or knowledge or consent of the insured;

(10) make claims payments to insureds or beneficiaries not accompanied by statements setting forth the coverage under which the payments are being made;
(11) make known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

(12) delay the investigation or payment of claims by requiring an insured, claimant, or physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(13) fail to promptly settle claims, if 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; or

(14) fail 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.
Acknowledgment of Claim

Under Nebraska law, insurers must acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies. See R.R.S. Neb. § 44-1540(2).

Furthermore, insurers must mail or otherwise provide to the claimant a notification of all items, statements and forms, if any, which the insurer reasonably believes will be required of the claimant within 15 working days. See R.R.S. Neb. § 44-1540(14).

Prompt, Fair and Equitable Settlement of Claims

Under Nebraska law, insurers must advise first-party claimants of the acceptance or denial of the claim within a reasonable time after receipt by the insurer of properly executed proofs of loss. See R.R.S. Neb. § 44-1540(8).
§ 44-1540. Unfair claims settlement practice; acts and practices prohibited

Any of the following acts or practices by an insurer, if committed in violation of section 44-1539, shall be an unfair claims settlement practice:

1. Knowingly misrepresenting to claimants and insureds relevant facts or policy provisions relating to coverages at issue;

2. Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies;

3. Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies;

4. Not attempting in good faith to effectuate prompt, fair, and equitable settlement of claims submitted in which liability has become reasonably clear;

5. Not attempting in good faith to effectuate prompt, fair, and equitable settlement of property and casualty claims (a) in which coverage and the amount of the loss are reasonably clear and (b) for loss of tangible personal property within real property which is insured by a policy subject to section 44-501.02 and which is wholly destroyed by fire, tornado, windstorm, lightning, or explosion;

6. Compelling insureds or beneficiaries to institute litigation to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in litigation brought by them;

7. Refusing to pay claims without conducting a reasonable investigation;

8. Failing to affirm or deny coverage of a claim within a reasonable time after having completed its investigation related to such claim;

9. Attempting to settle a claim for less than the amount to which a reasonable person would believe the insured or beneficiary was entitled by reference to written or printed advertising material accompanying or made part of an application;

10. Attempting to settle claims on the basis of an application which was materially altered without...
(11) Making a claims payment to an insured or beneficiary without indicating the coverage under which each payment is being made;

(12) Unreasonably delaying the investigation or payment of claims by requiring both a formal proof-of-loss form and subsequent verification that would result in duplication of information and verification appearing in the formal proof-of-loss form;

(13) Failing, in the case of the denial of a claim or the offer of a compromise settlement, to promptly provide a reasonable and accurate explanation of the basis for such action;

(14) Failing to provide forms necessary to present claims with reasonable explanations regarding their use within fifteen working days of a request;...
**NEVADA**

**Acknowledgment of Claim**

Under Nevada law, insurers must acknowledge the receipt of a notification of claim within **20 working days** after receiving it, unless payment is made within such period of time. See Nev. Admin. Code ch. 686A.665(1).

Furthermore, insurers must promptly provide all necessary claim forms, instructions, and reasonable assistance so that first-party claimants can comply with policy conditions. Compliance with this paragraph within **20 working days** of notification of a claim constitutes compliance with the above paragraph. See Nev. Admin. Code ch. 686A.665(4).

Also, insurers must make an appropriate reply within **20 working days** to all other pertinent communications from a claimant which reasonably suggest that a response is expected. See Nev. Admin. Code ch. 686A.665(3).

**Prompt, Fair and Equitable Settlement of Claims**

Under Nevada law, insurers must advise first-party claimants of the acceptance or denial of the claim within **30 working days** after receipt by the insurer of properly executed proofs of loss. A denial must be in writing and filed and retained in the insurer’s claim file. See Nev. Admin. Code ch. 686A.675(1).

If more time is needed to determine acceptance or denial, the insurer must notify the first-party claimant within **30 working days** after receipt of the proofs of loss, giving reasons more time is needed. See Nev. Admin. Code ch. 686A.675(3).

If the investigation remains incomplete, the insurer must send the claimant a letter **30 days** from the date of initial notification and every **30 days** thereafter, setting forth the reasons additional time is needed for investigation. See Nev. Admin. Code ch. 686A.675(3).
NEVADA ADMINISTRATIVE CODE
CHAPTER 686A. TRADE PRACTICES AND FRAUDS
UNFAIR PRACTICES
STANDARDS CONCERNING CLAIMS

(Current with amendments included in the State of Nevada Register of Administrative Regulations, Volume 116, dated April 30, 2007)

NAC 686A.665. Insurer to acknowledge receipt of claim notice within certain period; insurer, agent or administrator to respond adequately and within certain period to inquiry from Division respecting claim filed with Division; reply required within certain period to certain communications from claimants. (NRS 679B.130, 686A.015, 686A.310)

1. Every insurer shall acknowledge the receipt of a claim notice within 20 working days after receipt of the claim notice unless payment of the claim is made within that time. If acknowledgment is made by means other than writing, an appropriate dated notation of the acknowledgment must be made in the claim file of the insurer. Notice given to an agent of an insurer is notice to the insurer.

2. Each insurer, agent or administrator, upon receipt of any inquiry from the division respecting a claim filed with the division shall, within 10 working days after receipt of the inquiry, furnish the division with an adequate response to the inquiry. The division will not consider an acknowledgment of the receipt of an inquiry to be an adequate response to the inquiry. An insurer, agent or administrator who has received such an inquiry may request an extension of time, not to exceed 20 working days, to submit an adequate response. The request for an extension must be furnished to the division within 10 working days after the insurer, agent or administrator received the inquiry.

3. An appropriate reply must be made within 20 working days after receipt of any other pertinent communication from a claimant if the communication reasonably suggests that a response is expected.

4. Each insurer, upon receiving notification of claim, shall promptly provide necessary claim forms, instructions and reasonable assistance so that first-party claimants can comply with the policy conditions and the insurer’s reasonable requirements. Compliance with this subsection within 20 working days after receipt of notification of a claim constitutes compliance with subsection 1.

5. As used in this section, "administrator" has the meaning ascribed to it in NRS 683A.025.

NAC 686A.675 Standards applicable to all insurers. (NRS 679B.130, 686A.015, 686A.310)

1. Within 30 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant must be advised of the acceptance or denial of the claim by the insurer. No insurer may deny a claim on the grounds of a specific policy provision, condition or exclusion unless reference to that provision, condition or exclusion is included in the denial. The denial must be given to the claimant in writing and filed and retained in the insurer’s claim file. If the claim of the first-party claimant is accepted, the insurer shall pay the claim within 30 days after it is accepted. If the accepted claim is not paid within that period, the insurer shall pay interest on the claim at the rate of interest established
pursuant to NRS 99.040. The interest must be calculated from the date on which the payment is due until the claim is paid.

2. If a claim is denied for reasons other than those described in subsection 1, and is made by any means other than writing, an appropriate notation must be made in the claim file of the insurer.

3. If the insurer needs more time to determine whether a claim of a first-party claimant should be accepted or denied, it must so notify the claimant within 30 working days after receipt of the proof of loss giving reasons that more time is needed. If the investigation remains incomplete, the insurer shall, 30 days after the date of the initial notification and every 30 days thereafter, send to the claimant a letter setting forth the reasons that additional time is needed for investigation.

4. Insurers may not fail to settle first-party claims on the basis that responsibility for payment should be assumed by others except as provided by policy provisions.

5. Insurers may not delay settlement of a claim directly with a claimant who is not an attorney or represented by an attorney by extending negotiations until the claimant’s rights may be affected by a statute of limitations or a time limit which is part of an insurance contract or policy, without giving the claimant written notice that the time limit may be expiring and may affect the claimant’s rights. Notice must be given 60 days before the date on which a time limit may expire.

6. No insurer may make statements which indicate that the rights of a third-party claimant may be impaired if a form or release is not completed within a given time, unless the statement is given for the purpose of notifying the third-party claimant of the provision of a statute of limitations.

7. Except for a claim involving health insurance, any case involving a claim in which there is a dispute over any portion of the insurance policy coverage, payment for the portion or portions not in dispute must be made notwithstanding the existence of the dispute where payment can be made without prejudice to any interested party.
NEW HAMPSHIRE

Acknowledgment of Claim

Under New Hampshire law, insurers must acknowledge the receipt of a notification of claim within 10 working days after receiving it. This requirement of written acknowledgment shall not preclude a speedier method of acknowledgment where the circumstances warrant. See N.H. Code Admin. R. Ann. Ins. 1001.01(a).

Also, insurers must make an appropriate reply within 10 working days to all other pertinent communications from insureds, claimants, or authorized representatives of either. See N.H. Code Admin. R. Ann. Ins. 1001.01(b).

Prompt, Fair and Equitable Settlement of Claims

Under New Hampshire law, insurers must advise insureds or claimants of the acceptance or denial of the claim within 10 working days after receipt of a notice of a claim from the insured. Either an acceptance or a denial must be in writing. See N.H. Code Admin. R. Ann. Ins. 1001.02(c).

If more time is needed to determine acceptance or denial, the insurer must notify insureds or claimants within 10 working days after receipt of the proofs of loss, giving reasons more time is needed. See N.H. Code Admin. R. Ann. Ins. 1001.02(c).

If the investigation remains incomplete, the insurer must send the claimant a letter 30 days from the date of initial notification and every 30 days thereafter setting forth the reasons additional time is needed for investigation. See N.H. Code Admin. R. Ann. Ins. 1001.02(d).
Ins 1001.01 Communications Time Limit.

(a) Every insurer, upon notice of a claim, shall acknowledge the receipt of such notice in writing within 10 working days. This requirement of written acknowledgment shall not preclude a speedier method of acknowledgment where the circumstances warrant. Notification given to an agent of an insurer shall be notification to the insurer. If the notification is given to the agent of an insurer, such agent may acknowledge receipt of such notice. Unless otherwise provided by law or contract, notice to an agent of an insurer shall not be notice to the insurer if such agent notifies the claimant within 5 working days that the agent is not authorized to receive notices of claims.

(b) Every insurer shall reply within 10 working days to all claims communications from insureds, claimants, or authorized representatives of either.

(c) Every insurer, upon receipt of an inquiry from the insurance department shall within 10 working days furnish the department with a complete and accurate written response to the inquiry.

Ins 1001.02 Claims Settlement Time Limits.

(a) A complete decision regarding member payment or coverage or denial shall be made by the insurer within 30 days of receipt of any health insurance claim. In the event of extenuating circumstances, if a complete coverage decision is not made within 30 days, the insurer shall provide a written explanation to the member claimant justifying such delay. This provision shall not apply to provider submitted claims for reimbursement for services which have been provided to members.

(b) Unless otherwise provided by law, every insurer shall establish procedures to commence an investigation of any claim filed by an insured, claimant or authorized representative of either within 5 working days upon receipt of notice of loss. The procedures established should anticipate the seasonal changes in the volume of claims. Every insurer shall mail to every insured, claimant, policyholder or their authorized representative a notification of all items, statements or forms as well as blank copies of all statements or forms which the insurer reasonably believes will be required in the settlement of the claim.

(c) Unless otherwise provided by law, within 10 working days after acknowledgment of the receipt of a notice of a claim from the insured, claimant or authorized representative of either, the insurer shall
advise the insured, claimant or authorized representative of either in writing of the acceptance or rejection of the claim. If the insurer needs more time to determine whether the claim should be accepted or rejected, the insurer shall so notify the insured, claimant or authorized representative of either within 10 working days after acknowledgement of the loss and provide the reasons for the delay.

(d) The insurer shall within 30 days from the date of the letter setting forth a need for further time and every 30 days thereafter, send to the insured, claimant or authorized representative of either a letter setting forth the reasons for the delay in the claim settlement, unless the insured, claimant or authorized representative otherwise agrees.

(e) An insurer shall not justify a delay in processing or paying a claim on the grounds of suspected fraud unless the insurer has notified the department and has provided the department with specific reasons to support their suspicions.

(f) Whenever the insurer denies a claim on the basis of no coverage or the amount of loss is below the deductible, the insurer shall inform the insured in writing the reason for the denial and include the department’s toll-free telephone number.

(g) Any letter setting forth the need for further time after the first 30-day period shall contain the following statement:

‘Should you wish to take this matter up with the New Hampshire insurance department, it maintains a service division to investigate complaints at 56 Old Suncook Road, Concord, NH, 03301. The New Hampshire insurance department can be reached, toll-free, by dialing 1-800-852-3416.’

(h) Unless otherwise provided by law, every insurer shall pay any amount finally agreed upon in settlement of all or part of a claim not later than 5 working days from the date of such agreement or from the date of the performance by the insured, claimant or authorized representative of either of all conditions set forth by such agreement.

(i) An insurer shall not request of a claimant or insured a waiver of insurer obligations under Ins 1000, except to request a waiver of the 30 day delay letter provision of this rule. This waiver shall be in writing and signed by the insured or claimant. The signed waiver shall be retained in the claim file.
NEW JERSEY

Acknowledgment of Claim

Under New Jersey law, insurers must acknowledge the receipt of a notification of claim within 10 working days after receiving it, unless payment is made within such period of time. See N.J. Admin. Code tit. 11, § 2-17.6(b).

Furthermore, insurers must promptly provide all necessary claim forms, instructions, and reasonable assistance so that first-party claimants can comply with policy conditions. Compliance with this paragraph within 10 working days of notification of a claim shall constitute compliance with the above paragraph. See N.J. Admin. Code tit. 11, § 2-17.6(c).

Also, insurers must make an appropriate reply within 10 working days to all other pertinent communications from a claimant which reasonably suggest that a response is expected. See N.J. Admin. Code tit. 11, § 2-17.6(e).

Prompt, Fair and Equitable Settlement of Claims

Under New Jersey law, insurers must commence an investigation on all claims other than auto insurance physical damage within 10 working days after receipt by the insurer of notification of claim. See N.J. Admin. Code tit. 11, § 2-17.7(a).

Unless a clear justification exists, or unless otherwise provided by law, the maximum payment periods for property/liability claims shall be as follows: for all first-party claims other than personal injury protection and auto physical damage, 30 calendar days from receipt by the insurer of properly executed proofs of loss; and for all third party property damage claims, 45 calendar days from receipt by the insurer of notification of claim. See N.J. Admin. Code tit. 11, § 2-17.7(c).

If the insurer is unable to settle the claim within the time period specific in the preceding paragraph, the insurer must send the claimant written notice by the end of such period of time. The written notice must state the reasons additional time is needed, and must include the address of the office responsible for handling the claim and the insured’s policy number and claim number. The notice shall include a telephone number which is toll free, which can be called collect, or which is within the claimant’s area code. See N.J. Admin. Code tit. 11, § 2-17.7(e).

The insurer must send the claimant an updated written notice setting forth the reasons additional time is needed within 45 days from the date of initial notification and every 45 days thereafter until all elements of the claim are either honored or rejected. See N.J. Admin. Code tit. 11, § 2-17.7(e).
11:2-17.6 Rules for replying to pertinent communications

(a) All claims must be reported to the designated insurer by a broker no later than three working days following receipt of notification of claim by the broker. For the purposes of this subsection, "broker" shall include a producer of record with respect to any residual market mechanism created by statute.

(b) Every insurer, upon receiving notification of claim shall, within 10 working days, acknowledge receipt of such notice unless payment is made within such period of time. This acknowledgement shall include the address and telephone number of the insurer claims office or authorized claims representative which will handle the claim. Notification given to an agent of an insurer shall be considered notice to the insurer.

(c) Every insurer, upon receiving notification of claim, shall promptly provide first party claimants with necessary claim forms, instructions, and reasonable assistance so that such claimants can comply with the policy conditions and the insurer's reasonable requirements. Compliance with this subsection (c) within 10 working days of notification of a claim shall constitute compliance with (b) above.

(d) Every insurer, upon receipt of any inquiry from the Department respecting a claim shall, within 15 working days of receipt of such inquiry, furnish the Department with, based on the information available to the insurer, a complete and accurate written response to the inquiry.

(e) An appropriate reply shall be made within 10 working days on all other pertinent communications from a claimant which reasonably suggest that a response is expected.

11:2-17.7 Rules for prompt investigation and settlement of claims

(a) Every insurer shall commence an investigation on all claims other than auto physical damage within 10 working days of receipt of notification of claim.

(b) The maximum payment period for all personal injury protection (PIP) claims shall be 60 calendar days after the insurer is furnished written notice of the fact of a covered loss and of the amount of same; provided, however, that an insurer may secure a 45-day extension in accordance with N.J.S.A. 39:6A-5.

(c) Unless a clear justification exists, or unless otherwise provided by law, the maximum payment periods for property/liability claims shall be as follows:

1. For all first party claims other than personal injury protection (PIP) and auto physical damage (see N.J.A.C. 11:3-10.5(a)), 30 calendar days from receipt by the insurer of properly executed proofs of loss.

2. For all third party property damage claims, 45 calendar days from receipt by the insurer of notification of claim.

3. For all third party bodily injury claims, 90 calendar days from receipt by the insurer of notification of claim.

(d) Rules for the payment of health insurance claims may be found at N.J.A.C. 11:22-1.
(e) If the insurer is unable to settle the claim within the time periods specified in (c) through (e) above, the insurer must send the claimant written notice by the end of the payment periods specified in (c) through (e) above. The written notice must state the reasons additional time is needed, and must include the address of the office responsible for handling the claim and the insured’s policy number and claim number. This notice shall also include a telephone number which is toll free, or which can be called collect, or which is within the claimant’s area code. This number shall provide direct access to the responsible claims office or shall enable the claimant to gain such access at no greater expense than the cost of a telephone call within his or her area code. An updated written notice setting forth the reasons additional time is needed shall be sent within 45 days after the initial notice and within every 45 days thereafter until all elements of the claim are either honored or rejected. The written notifications required under this subsection shall not continue to apply to that aspect of a claim for which the claimant has become represented by an attorney, as evidenced by a letter of representation.

(f) Unless otherwise provided by law, every insurer shall pay any amount finally agreed upon in settlement of all or part of any claim not later than 10 working days from either the receipt of such agreement by the insurer or the date of the performance by the claimant of any conditions set by such agreement, whichever is later.

(g) Where there is a reasonable basis supported by specific information available for review by the Department that the first party claimant has fraudulently caused or contributed to the loss by arson, or claimant has become represented by an attorney, as evidenced by a letter of representation.

(h) Unless otherwise provided by statute or unless otherwise provided by the policy, all life insurance claims shall be paid within a maximum period of 60 calendar days. The payment period is defined as the period between the date proof of loss is received by the insurer and the date of claims settlement.

1. If a claim or a portion of a claim for benefits under a policy requires additional investigation or is denied by the insurer, the insurer shall notify the claimant of such fact in writing within 45 days of due proof of death. The insurer shall also notify the claimant of the reason the claim is being investigated or denied, except in certain cases involving fraud.

2. Any uncontested portion of a claim shall be paid within 60 days of receipt of due proof of death, proof of the interest of the claimant, or any other document or information requested by the insurer under the terms of the policy.

3. The insurer, upon receipt of any document or information requested relating to a claim or portion of a claim under investigation, shall pay the benefits for which the claim is made or deny the claim within 90 days of the receipt of the requested documentation.

4. Payment of a claim or a portion thereof that is not under investigation by the insurer shall be overdue if not remitted to the claimant by the insurer within 60 days following receipt of due proof of death, proof of the interest of the claimant, or any other document or information requested by the insurer.

5. Payment of a claim or a portion of a claim under investigation or denied that becomes eligible for payment shall be overdue if not remitted to the claimant by the insurer within 90 days following receipt of due proof of death, proof of interest of claimant or any other document or information requested by the insurer.

6. Overdue payments shall bear an annual rate of interest equal to the average rate of return of the State of New Jersey Cash Management Fund, established pursuant to N.J.S.A. 52:18A-90.4, for the preceding fiscal year rounded to the nearest one-half percent. Insurers may choose either the Fund’s State or Other-than State rates. However, insurers shall not be permitted to change the rate once chosen.
NEW MEXICO

Acknowledgment of Claim

Under New Mexico law, certain practices committed by an insurer with respect to claims, if performed with such frequency as to indicate a general business practice, are defined as unfair and deceptive practices and are prohibited. See N.M. Stat. Ann. § 59A-16-20.

One such practice is failing to acknowledge and act reasonably promptly upon communications with respect to claims from insured arising under policies. See N.M. Stat. Ann. § 59A-16-20(B).

Prompt, Fair and Equitable Settlement of Claims

Under New Mexico law, certain practices committed by an insurer with respect to claims, if performed with such frequency as to indicate a general business practice, are defined as unfair and deceptive practices and are prohibited. See N.M. Stat. Ann. § 59A-16-20.

One such practice is failing to adopt and implement reasonable standards for the prompt investigation and processing of insureds’ claims arising under policies. See N.M. Stat. Ann. § 59A-16-20(C).

Another such practice is failing to affirm or deny coverage of claims by insureds within a reasonable time after proof of loss requirements under the policy have been completed and submitted by the insured. See N.M. Stat. Ann. § 59A-16-20(D).

Another such practice is not attempting in good faith to effectuate prompt, fair and equitable settlements of an insured’s claims in which liability has become reasonably clear. See N.M. Stat. Ann. § 59A-16-20(E).
§ 59A-16-20. Unfair claims practices defined and prohibited

Any and all of the following practices with respect to claims, by an insurer or other person, knowingly committed or performed with such frequency as to indicate a general business practice, are defined as unfair and deceptive practices and are prohibited:

A. misrepresenting to insureds pertinent facts or policy provisions relating to coverages at issue;

B. failing to acknowledge and act reasonably promptly upon communications with respect to claims from insureds arising under policies;

C. failing to adopt and implement reasonable standards for the prompt investigation and processing of insureds' claims arising under policies;

D. failing to affirm or deny coverage of claims of insureds within a reasonable time after proof of loss requirements under the policy have been completed and submitted by the insured;

E. not attempting in good faith to effectuate prompt, fair and equitable settlements of an insured's claims in which liability has become reasonably clear;

F. failing to settle all catastrophic claims within a ninety-day period after the assignment of a catastrophic claim number when a catastrophic loss has been declared;

G. compelling insureds to institute litigation to recover amounts due under policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds when such insureds have made claims for amounts reasonably similar to amounts ultimately recovered;

H. attempting to settle a claim by an insured for less than the amount to which a reasonable person would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application;

I. attempting to settle claims on the basis of an application that was altered without notice to, or knowledge or consent of, the insured, his representative, agent or broker;

J. failing, after payment of a claim, to inform insureds or beneficiaries, upon request by them, of the coverage under which payment has been made;

K. making known to insureds or claimants a practice of insurer of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

L. delaying the investigation or payment of claims by requiring an insured, claimant or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

M. failing to settle an insured's claims promptly where liability has become apparent under one portion of the policy coverage in order to influence settlement under other portions of the policy coverage;
N. failing to promptly provide an insured a reasonable explanation of the basis relied on in the policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement; or

O. violating a provision of the Domestic Abuse Insurance Protection Act.
Acknowledgment of Claim

Under New York law, insurers must acknowledge the receipt of a notification of claim within 15 business days after receiving it, unless payment is made within such period of time. Such acknowledgment may be in writing, but if made by other means appropriate notation shall be made in the claim file of the insurer. See N.Y. Comp. Codes R. & Regs. tit. 11, § 216.4(a).

Also, insurers must make an appropriate reply within 15 business days on all other pertinent communications. See N.Y. Comp. Codes R. & Regs. tit. 11, § 216.4(b).

Prompt, Fair and Equitable Settlement of Claims

Under New York law, insurers must advise claimants in writing of the acceptance or denial of the claim within 15 business days after receipt by the insurer of properly executed proofs of loss and/or all other items, statements and forms which the insurer requested from the claimant. See N.Y. Comp. Codes R. & Regs. tit. 11, § 216.6(c).

If more time is needed to determine acceptance or denial, the insurer must notify the first-party claimant within 15 business days after receipt of the proofs of loss, giving the reasons more time is needed. See N.Y. Comp. Codes R. & Regs. tit. 11, § 216.6(c).

If the investigation remains incomplete, the insurer must send the claimant a letter 90 days from the date of initial letter setting forth the need for further time to investigate, and every 90 days thereafter, setting forth the reasons additional time is needed for investigation. See N.Y. Comp. Codes R. & Regs. tit. 11, § 216.6(c).
Section 216.4 Failure to acknowledge pertinent communications.

(a) Every insurer, upon notification of a claim, shall, within 15 business days, acknowledge the receipt of such notice. Such acknowledgment may be in writing. If an acknowledgment is made by other means, an appropriate notation shall be made in the claim file of the insurer. Notification given to an agent of an insurer shall be notification to the insurer. If notification is given to an agent of an insurer, such agent may acknowledge receipt of such notice. Unless otherwise provided by law or contract, notice to an agent of an insurer shall not be notice to the insurer if such agent notifies the claimant that the agent is not authorized to receive notices of claims.

(b) An appropriate reply shall be made within 15 business days on all other pertinent communications.

(c) Every insurer shall establish an internal department specifically designated to investigate and resolve complaints filed with the Insurance Department and to take action necessitated as a result of its complaint investigation findings. Such internal department is to operate in a staff capacity to the entire company with authority to question and change the position taken in individual instances or company practices generally. Responsibility for such department is to be vested in a corporate officer who is also to be entrusted with the duty of executing the Insurance Department’s directives. If the Insurance Department requests the appearance of an insurer representative to discuss a pending matter, the individual whom the company sends shall be authorized to make any determination warranted after all the facts are elicited at such conference. Each insurer must furnish the superintendent with the name and title of the corporate officer responsible for its internal consumer services department.

(d) Every insurer, upon receipt of any inquiry from the Insurance Department respecting a claim, shall, within 10 business days, furnish the department with the available information requested respecting the claim.

(e) As part of its complaint handling function, an insurer’s consumer services department shall maintain an ongoing central log to register and monitor all complaint activity.

Section 216.6 Standards for prompt, fair and equitable settlements.

(a) In any case where there is no dispute as to coverage, it shall be the duty of every insurer to offer claimants, or their authorized representatives, amounts which are fair and reasonable as shown by its investigation of the claim, providing the amounts so offered are within policy limits and in accordance with the policy provisions.
(b) Actual cash value, unless otherwise specifically defined by law or policy, means the lesser of the amounts for which the claimant can reasonably be expected to:

(1) repair the property to its condition immediately prior to the loss; or

(2) replace it with an item substantially identical to the item damaged. Such amount shall include all monies paid or payable as sales taxes on the item repaired or replaced. This shall not be construed to prevent an insurer from issuing a policy insuring against physical damage to property, where the amount of damages to be paid in the event of a total loss to the property is a specified dollar amount.

(c) Within 15 business days after receipt by the insurer of a properly executed proof of loss and/or receipt of all items, statements and forms which the insurer requested from the claimant, the claimant, or the claimant’s authorized representative, shall be advised in writing of the acceptance or rejection of the claim by the insurer. When the insurer suspects that the claim involves arson, the foregoing 15 business days shall be read as 30 business days pursuant to section 2601 of the Insurance Law. If the insurer needs more time to determine whether the claim should be accepted or rejected, it shall so notify the claimant, or the claimant’s authorized representative, within 15 business days after receipt of such proof of loss, or requested information. Such notification shall include the reasons additional time is needed for investigation. If the claim remains unsettled, unless the matter is in litigation or arbitration, the insurer shall, 90 days from the date of the initial letter setting forth the need for further time to investigate, and every 90 days thereafter, send to the claimant, or the claimant’s authorized representative, a letter setting forth the reasons additional time is needed for investigation. If the claim is accepted, in whole or in part, the claimant, or the claimant’s authorized representative, shall be advised in writing of the amount offered. In any case where the claim is rejected, the insurer shall notify the claimant, or the claimant’s authorized representative, in writing, of any applicable policy provision limiting the claimant’s right to sue the insurer.

(d) The company shall inform the claimant in writing as soon as it is determined that there was no policy in force or that it is disclaiming liability because of a breach of policy provisions by the policyholder. The insurer must also explain its specific reasons for disclaiming coverage.

(e) In any case where there is no dispute as to one or more elements of a claim, payment for such element(s) shall be made notwithstanding the existence of disputes as to other elements of the claim where such payment can be made without prejudice to either party.

(f) Every insurer shall pay any amount finally agreed upon in settlement of all or part of any claim not later than five business days from the receipt of such agreement by the insurer, or from the date of the performance by the claimant of any condition set by such agreement, whichever is later, except as provided in section 331 of the Insurance Law as respects liens by tax districts on fire insurance proceeds.

(g) Checks or drafts in payment of claims; releases. No insurer shall issue a check or draft in payment of a first-party claim or any element thereof, arising under any policy subject to this Part, that contains any language or provision that expressly or impliedly states that acceptance of such check or draft shall constitute a final settlement or release of any or all future obligations arising out of the loss. No insurer shall require execution of a release on a first- or third-party claim that is broader than the scope of the settlement.

(h) Any notice rejecting any element of a claim involving personal property insurance shall contain the identity and the claims processing address of the insurer, the insured’s policy number, the claim number, and the following statement prominently set out:
"Should you wish to take this matter up with the New York State Insurance Department, you may file with the Department either on its website at www.ins.state.ny.us/complhow.htm or you may write to or visit the Consumer Services Bureau, New York State Insurance Department, at: 25 Beaver Street, New York, NY 10004; One Commerce Plaza, Albany, NY 12257; 200 Old Country Road, Suite 340, Mineola, NY 11501; or Walter J. Mahoney Office Building, 65 Court Street, Buffalo, NY 14202."
Acknowledgment of Claim

Under North Carolina law, the Commissioner of Insurance is authorized to impose a civil penalty upon an insurer if the insurer fails to acknowledge a claim within 30 days after receiving written notice of the claim, but only if the notice contains sufficient information for the insurer to identify the specific coverage involved. See N.C. Gen. Stat. § 58-3-100(c).

Acknowledgment must be in a letter stating the claim is being investigated, or payment of the claim, or a bona fide written offer of settlement of claim, or written denial of claim. See N.C. Gen. Stat. § 58-3-100(c).

Furthermore, it is considered an unfair claim settlement practice if an insurer commits the following act – failing to acknowledge and act reasonably promptly upon communications with respect to claim arising under insurance policies – with such frequency as to indicate a general business practice, provided however, that no single violation shall of itself create any cause of action in favor of any person other than the Commissioner of Insurance. See N.C. Gen. Stat. § 58-63-15(11)(b).

Prompt, Fair and Equitable Settlement of Claims

Under North Carolina law, it is considered an unfair claim settlement practice if an insurer commits certain acts with such frequency as to indicate a general business practice, provided however, that no single violation shall of itself create a cause of action in favor of any person other than the Commissioner of Insurance. See N.C. Gen. Stat. § 58-63-15(11).

One such act is failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies. See N.C. Gen. Stat. § 58-63-15(11)(c).

Another such act is failing to affirm or deny coverage of claims within a reasonable time after proof-of-loss statements have been completed. See N.C. Gen. Stat. § 58-63-15(11)(e).

Another such act is not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear. See N.C. Gen. Stat. § 58-63-15(11)(f).
§ 58-3-100. Insurance company licensing provisions

(a) The Commissioner may, after notice and opportunity for a hearing, revoke, suspend, or restrict the license of any insurer if:

(1) The insurer fails or refuses to comply with any law, order or rule applicable to the insurer.

(2) After considering the standards under G.S. 58-30-60(b), the Commissioner determines that the continued operation of the insurer is hazardous to its policyholders, to its creditors, or to the general public.

(3) The insurer has published or made to the Department or to the public any false statement or report.

(4) The insurer or any of the insurer’s officers, directors, employees, or other representatives refuse to submit to any examination authorized by law or refuse to perform any legal obligation in relation to an examination.

(5) The insurer is found to make a practice of unduly engaging in litigation or of delaying the investigation of claims or the adjustment or payment of valid claims.

(b) Any suspension, revocation or refusal to renew suspension or revocation of an insurer’s license under this section may also be made applicable to the license or registration of any individual regulated under this Chapter who is a party to any of the causes for licensing sanctions listed in subsection (a) of this section.

(c) The Commissioner may impose a civil penalty under G.S. 58-2-70 if an HMO, service corporation, MEWA, or insurer fails to acknowledge a claim within 30 days after receiving written or electronic notice of the claim, but only if the notice contains sufficient information for the insurer to identify the specific coverage involved. Acknowledgement of the claim shall be one of the following:

(1) A statement made to the claimant or to the claimant’s legal representative advising that the claim is being investigated.

(2) Payment of the claim.

(3) A bona fide written offer of settlement.

(4) A written denial of the claim.

A claimant includes an insured, a beneficiary of a life or annuity contract, a health care provider, or a health care facility that is responsible for directly making the claim with an insurer, HMO, service corporation, or MEWA. With respect to a claim under an accident, health, or disability policy, if the acknowledgement sent to the claimant indicates that the claim remains under investigation, within 45 days after receipt by the insurer of the initial claim, the insurer shall send a claim status report to the insured and every 45 days thereafter until the claim is paid or
denied. The report shall give details sufficient for the insured to understand why processing of the claim has not been completed and whether the insurer needs additional information to process the claim. If the claim acknowledgement includes information about why processing of the claim has not been completed and indicates whether additional information is needed, it may satisfy the requirement for the initial claim status report. This subsection does not apply to HMOs, service corporations, MEWAs or insurers subject to G.S. 58-3-225.

(d) If a foreign insurance company's license is suspended or revoked, the Commissioner shall cause written notification of the suspension or revocation to be given to all of the company's agents in this State. Until the Commissioner restores the company's license, the company shall not write any new business in this State.

(e) The Commissioner may, after considering the standards under G.S. 58-30-60(b), restrict an insurer's license by prohibiting or limiting the kind or amount of insurance written by that insurer. For a foreign insurer, this restriction relates to the insurer's business conducted in this State. The Commissioner shall remove any restriction under this subsection once the Commissioner determines that the operations of the insurer are no longer hazardous to the public or the insurer's policyholders or creditors. As used in this subsection, 'insurer' includes an HMO, service corporation, and MEWA.

WEST'S NORTH CAROLINA GENERAL STATUTES ANNOTATED
CHAPTER 58. INSURANCE
ARTICLE 63. UNFAIR TRADE PRACTICES

§ 58-63-15. Unfair methods of competition and unfair or deceptive acts or practices defined

The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance: . . .

(11) Unfair Claim Settlement Practices.--Committing or performing with such frequency as to indicate a general business practice of any of the following: Provided, however, that no violation of this subsection shall of itself create any cause of action in favor of any person other than the Commissioner:

a. Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

b. Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

c. Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

d. Refusing to pay claims without conducting a reasonable investigation based upon all available information;

e. Failing to affirm or deny coverage of claims within a reasonable time after proof-of-loss statements have been completed;
f. Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;
g. Compelling insured to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insured;
h. Attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled;
i. Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of, the insured;
j. Making claims payments to insureds or beneficiaries not accompanied by statement setting forth the coverage under which the payments are being made;
k. Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;
l. Delaying the investigation or payment of claims by requiring an insured claimant, or the physician, of either, (FN1) to submit a preliminary claim report and then requiring the subsequent submission of formal proof-of-loss forms, both of which submissions contain substantially the same information;
m. 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; and
n. 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.
Acknowledgment of Claim

Under North Dakota law, certain practices committed by an insurer with respect to claims, if performed with such frequency as to indicate a general business practice, are defined as unfair and deceptive practices and are prohibited. See N.D. Cent. Code § 26.1-04-03(9).

One such practice is failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under policies. See N.D. Cent. Code § 26.1-04-03(9)(b).

Prompt, Fair and Equitable Settlement of Claims

Under North Dakota law, certain practices committed by an insurer with respect to claims, if performed with such frequency as to indicate a general business practice, are defined as unfair and deceptive practices and are prohibited. See N.D. Cent. Code § 26.1-04-03(9).

One such practice is failing to adopt and implement reasonable standards for the prompt investigation of claims arising under policies. See N.D. Cent. Code § 26.1-04-03(9)(c).

Another such practice is not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonable clear. See N.D. Cent. Code § 26.1-04-03(9)(d).
26.1-04-03 Unfair methods of competition and unfair or deceptive acts or practices defined.

The following are unfair methods of competition and unfair and deceptive acts or practices in the business of insurance: . . .

9. Unfair claim settlement practices. Committing any of the following acts, if done without just cause and if performed with a frequency indicating a general business practice:

a. Knowingly misrepresenting to claimants pertinent facts or policy provisions relating to coverages at issue.

b. Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under insurance policies.

c. Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.

d. Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims submitted in which liability has become reasonably clear.

e. Compelling insureds to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them when the insureds have made claims for amounts reasonably similar to the amounts ultimately recovered.

f. Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

g. Attempting settlement or compromise of claims on the basis of applications which were altered without notice to, or knowledge or consent of, insureds.

h. Attempting to settle a claim for less than the amount to which a reasonable person would have believed one was entitled by reference to written or printed advertising material accompanying or made a part of an application.

i. Attempting to delay the investigation or payment of claims by requiring an insured and the insured’s physician to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information.
j. Failing to affirm or deny coverage of claims within a reasonable time after proof of loss has been completed.

k. Refusing payment of claims solely on the basis of the insured's request to do so without making an independent evaluation of the insured's liability based upon all available information.

l. Providing coverage under a policy issued under chapter 26.1-45 or 26.1-36.1 for confinement to a nursing home and refusing to pay a claim when a person is covered by such a policy and the person's physician ordered confinement pursuant to the terms of the policy for care other than custodial care. Custodial care means care which is primarily for the purpose of meeting personal needs without supervision by a registered nurse or a licensed practical nurse.

m. Failure to use the standard health insurance proof of loss and claim form or failure to pay a health insurance claim as required by section 26.1-36-37.1.

It is not a prohibited practice for a health insurance company with participating provider agreements to require that a subscriber or member using a nonparticipating provider be responsible for providing the insurer a copy of medical records used for claims processing.
Acknowledgment of Claim

Under Ohio law, an insurer must acknowledge the receipt of a claim within 10 days of receiving such notification. An insurer may satisfy this requirement by making payment within this 10 day period. An insurer may also satisfy this requirement by providing necessary claims forms and complete instructions to the claimant. See Ohio Admin. Code § 3901-1-54(F)(2).

An insurer must respond within 15 days to any communication from a claimant, when that communication suggests a response is appropriate. In the event of a lawsuit, the insurer is not obligated to respond within this 15 day period but rather the appropriate rule of procedure for the court will apply. See Ohio Admin. Code § 3901-1-54(F)(3).

Prompt, Fair and Equitable Settlement of Claims

Under Ohio law, an insurer must decide within 21 days of receipt of properly executed proofs of loss whether to accept or deny a claim. See Ohio Admin. Code § 3901-1-54(G)(1).

If more time is needed to investigate the claim, the insurer must notify the claimant within the 21 day period, and provide an explanation of the need for more time. See Ohio Admin. Code § 3901-1-54(G)(1).

If an extension of time is needed, the insurer has a continuing obligation to notify the claimant in writing, at least every 45 days, of the status of the investigation and the need for more time. See Ohio Admin. Code § 3901-1-54(G)(1).
3901-1-54 Unfair property/casualty claims settlement practices

(A) Authority

This rule is issued pursuant to the authority vested in the superintendent under sections 3901.19 to 3901.26 of the Revised Code.

(B) Purpose

The purpose of this rule is to set forth uniform minimum standards for the investigation and disposition of property and casualty claims arising under insurance contracts or certificates issued to residents of Ohio. It is not intended to cover claims involving workers’ compensation, or fidelity, suretyship, and boiler and machinery insurance. The provisions of this rule are intended to define procedures and practices which constitute unfair claims practices. Nothing in this rule shall be construed to create or imply a private cause of action for violation of this rule.

(C) Definitions

As used in this rule:

(1) "Agent" means any individual, corporation, association, partnership or other legal entity authorized to represent an insurer with respect to a claim;

(2) "Claim file" means any retrievable electronic file, paper file, combination of both, or any other media;

(3) "Claimant" means a first party claimant, a third party claimant.

(4) "Contract" means any insurance policy or document containing the terms of the agreement wherein one party, the insurer, assumes certain obligations including financial obligations that arise as a result of a loss sustained by another party, the insured, or to any other party that has rights under the agreement.

(5) "Days" means calendar days. However, when the last day of a time limit stated in this rule falls on a Saturday, Sunday, or holiday, the time limit is extended to the next immediate following day that is not a Saturday, Sunday, or holiday.

(6) "Department" means the Ohio department of insurance
(7) "Documentation" includes, but is not limited to, all communications, transactions, notes, work papers, claim forms, bills and explanation of benefits forms pertaining to the claim;

(8) "First party claimant" means any individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by the policy or contract;

(9) "Insurer" shall be defined as set forth in division (D) of section 3901.32 of the Revised Code;

(10) "Investigation" means all activities of an insurer directly or indirectly related to the determination of liability under an insurance contract which is in effect or alleged to be in effect;

(11) "Like kind and quality part" means a salvage motor vehicle part equal to or better than the replaced part that is acquired from a licensed salvage motor dealer.

(12) "Notification of claim" means any notification, under the terms of an insurance contract, to an insurer or its agent, by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim;

(13) "Person" shall be defined as set forth in section 3901.19 of the Revised Code;

(14) "Practice" means a type of activity or conduct engaged in by an insurer with such frequency as to constitute a customary procedure or policy routinely followed in the settlement of insurance claims. A single act is not a business practice. However, an act that is malicious, deliberate, conscious and knowing may be the basis for corrective action ordered only by the superintendent without a showing that the conduct is a practice.

(15) "Replacement crash part" means sheet metal or any plastic parts which generally constitute the exterior of a motor vehicle, including inner and outer panels;

(16) "Superintendent" means the superintendent of insurance;

(17) "Third party claimant" means any individual, corporation, association, partnership or other legal entity asserting a claim against any other individual, corporation, association, partnership or legal entity;

(18) "Written communications" includes any correspondence, regardless of source or type, that is materially related to a claim;

(19) "Proof of loss" means a document from the claimant that provides sufficient information from which the insurer can determine the existence and the amount of the claim.

(F) Response to acknowledge receipt of pertinent communications

(1) Notification of a claim given to an agent of an insurer shall be notification to the insurer.
(2) An insurer shall acknowledge the receipt of a claim within fifteen days of receiving such notification. An insurer may satisfy this requirement by making payment within this ten day period. An insurer may also satisfy this requirement by providing necessary claim forms and complete instructions to the claimant.

(3) An insurer shall respond within fifteen days to any communication from a claimant, when that communication suggests a response is appropriate. In the event that a complaint has been filed by a claimant in any court, an insurer is not obligated to respond within this time period and any communication between the claimant and the insurer will be subject to the appropriate rule of procedure for the court in which the lawsuit was filed.

(4) An insurer shall, within twenty-one days of receipt of an inquiry from the department regarding a claim, furnish the department with a reasonable response to the inquiry.

(G) General standards for settlement of claims

(1) An insurer shall within twenty-one days of the receipt of properly executed proof(s) of loss decide whether to accept or deny such claim(s). If more time is needed to investigate the claim than the twenty-one days allow, the insurer shall notify the claimant within the twenty-one day period, and provide an explanation of the need for more time. If an extension of time is needed, the insurer has a continuing obligation to notify the claimant in writing, at least every forty-five days of the status of the investigation and the continued time for the investigation.

If the form and execution of a proof of loss is material to an insurer, the insurer shall immediately provide the claimant with the specific documents and specific instructions so the claimant can submit the claim. An insurer shall not otherwise deny a claim solely on the basis the proof of loss is not on the insurer’s usual form.

If an insurer reasonably believes, based upon information obtained and documented within the claim file, that a claimant has fraudulently caused or contributed to the loss as represented by a properly executed and documented proof of loss, such information shall be presented to the fraud division of the department within sixty days of receipt of the proof of loss. Any person making such report shall be afforded such immunity and the information submitted will be confidential as provided by sections 3901.44 and 3999.31 of the Revised Code.

(2) No insurer shall deny a claim on the grounds of a specific policy provision, condition or exclusion unless reference to such provision, condition, or exclusion is included in the denial. The claim file of the insurer shall contain documentation of the denial in accordance with paragraph (D) of this rule.

(3) Except as otherwise provided by policy provisions, an insurer shall settle first party claims upon request by the insured with no consideration given to whether the responsibility for payment should be assumed by others.

(4) No insurer shall require an insured to submit to a polygraph examination unless authorized under the applicable insurance contract.
(5) Notice shall be given to claimants at least sixty days, before the expiration of any statute of limitation or contractual limit, where the insurer has not been advised that the claimant is represented by legal counsel.

(6) An insurer shall tender payment to a first party claimant no later than ten days after acceptance of a claim if the amount of the claim is determined and is not in dispute, unless the settlement involves a structured settlement, action by a probate court, or other extraordinary circumstances as documented in the claim file.

(7) If a claim involves a non-negligent party’s property loss and multiple liability insurers, the multiple liability insurers shall adjust the property loss within a reasonable time and pay the non-negligent party’s loss in equal shares. After payment, the multiple liability insurers may then pursue available remedies to resolve the question of responsibility for the non-negligent party’s loss.

(8) If a claim involves multiple coverages under any policy, no insurer shall withhold payment under any such coverage when the payment is known, the payment is not in dispute, and the payment would extinguish the insurer’s liability under that coverage. No insurer shall withhold such payment for the purpose of forcing settlement on all other coverage to effect a single payment.

(9) An insurer must document the application of comparative negligence to any claim settlement. Such information shall be fully disclosed to the claimant upon the claimant’s written request. An insurer shall not use pattern settlements as set forth in division (P) of section 3901.21 of the Revised Code.

(10) An insurer shall not use settlement practices that result in compelling first party claimants to litigate by offering substantially less than the amounts claimed compared to the amount ultimately recovered in actions brought by such claimants.
Acknowledgment of Claim

Under Oklahoma law, every property and casualty insurer must acknowledge the receipt of a notification of claim within 20 business days after receiving it, unless payment is made within such period of time. See Okla. Admin. Code 365:15-3-5(a).

Furthermore, insurers must promptly provide all necessary claim forms, instructions, and reasonable assistance so that the first-party claimants can comply with policy conditions. Compliance with this paragraph within 20 business days of notification of a claim shall constitute compliance with the above paragraph. See Okla. Admin. Code 365:15-3-5(d).

Also, insurers must make an appropriate reply within 20 business days to all other pertinent communications from a claimant which reasonably suggest that a response is expected. See Okla. Admin. Code 365:15-3-5(c).

Prompt, Fair and Equitable Settlement of Claims

Under Oklahoma law, property and casualty insurers must advise first-party claimants of the acceptance or denial of the claim within 45 business days after receipt by the insurer of properly executed proofs of loss. A denial must be in writing and include reference to a specific policy provision. See Okla. Admin. Code 365:15-3-7(a)(1).

If more time is needed to determine acceptance or denial, the insurer must notify the first-party claimant within 45 business days after receipt of the proofs of loss, giving reasons more time is needed. See Okla. Admin. Code 365:15-3-7(c).

If the investigation remains incomplete, the insurer must send the claimant a letter 45 days from the date of initial notification and every 45 days thereafter, setting forth the reasons additional time is needed for investigation. See Okla. Admin. Code 365:15-3-7(c).
365:15-3-5. Failure to acknowledge pertinent communications

(a) Acknowledgment of receipt of claim. Every property and casualty insurer, upon receiving notification of a claim shall, within 20 business days, acknowledge the receipt of such notice unless payment is made within such period of time. If any acknowledgment is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insured and dated. Notification given to an agent of an insurer shall be notification to the insurer.

(b) Response to inquiries from Insurance Department. Every property and casualty insurer, upon receipt of any inquiry from the Insurance Department respecting a claim shall, within fifteen business days of receipt of such inquiry, furnish the Department with an adequate response to the inquiry.

(c) Response to other pertinent communications. An appropriate reply shall be made within 20 business days on all other pertinent communications from a claimant which reasonably suggests that a response is expected.

(d) Insurer shall provide forms and assistance on claims to first party claimants. Every property and casualty insurer, upon receiving notification for claim, shall promptly provide necessary claim forms, instructions, and reasonable assistance so that first party claimants can comply with the policy conditions and the insurer’s reasonable requirements. Compliance with this paragraph within 20 business days of notification of a claim shall constitute compliance with subsection (a) of this section.

365:15-3-7. Standards for prompt, fair and equitable settlements applicable to all insurers

(a) Claims accepted or denied within 45 days.

(1) Within 45 business days after receipt by the property and casualty insurer of properly executed proof of loss, the first party claimant shall be advised of the acceptance or denial of the claim by the insurer. If investigation cannot reasonably be completed within such time the insurer shall notify the claimant within 45 business days after receipt of the proofs of loss giving reasons why more time is needed. No insurer shall deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to such provision, condition, or exclusion is included in the denial. The denial must be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial.

(2) Where there is a reasonable basis supported by specific information available for review by the Commissioner that the first party claimant had fraudulently caused or contributed to the loss by arson, the insurer is relieved from the requirements of this section. Provided, however, that the claimant shall be advised of the acceptance or denial of the claim
within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.

(b) Notation of denial in claim file until confirmed in writing. If a claim is denied for reasons other than those described in (a) of this section and is made by any other means than writing, an appropriate notation shall be made in the claim file of the property and casualty insurer until such time as a written confirmation can be made.

(c) Notification of delay in determination of acceptance or denial. If the property and casualty insurer needs more time to determine whether a first party claim should be accepted or denied, it shall so notify the first party claimant within 45 business days after receipt of the proofs of loss, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, forty-five days from the date of the initial notification and every forty-five days thereafter, send to such claimant a letter setting forth the reasons additional time is needed for investigation.

(d) Failure to settle on grounds of another party’s liability. Insurers shall not fail to settle first party claims on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions.

(e) Negotiations shall not be delayed unreasonably. Insurers shall not continue to delay negotiations for settlement with a claimant who is neither an attorney nor represented by an attorney, for a length of time which causes the claimant’s rights to be affected by a statute of limitations or a policy or contract time limit, without giving the claimant written notice that the time limit may be expiring and may affect the claimant’s rights. Such notice shall be given to first party claimants thirty days before the date on which such time limit may expire. Such notice shall be given to third party claimants sixty days before the date on which such time limit may expire.

(f) Rights of third party claimant. No insurer shall make statements which indicate that the rights of a third party claimant may be impaired if a form or release is not completed within a given period of time unless the statement is given for the purpose of notifying the third party claimant of a provision of a statute of limitations.

(g) Lawsuit supercedes time limitations. If a lawsuit on the claim is initiated, the time limits provided for in this section shall not apply.
Acknowledgment of Claim

Under Oregon law, insurers must acknowledge the receipt of a notification of claim within 30 days after receiving it. An appropriate and dated notation of the acknowledgment must be made in the insurer’s claim file. See Or. Admin. R. 836-080-0225(1).

Furthermore, insurers must promptly provide all necessary claim forms, instructions, and reasonable assistance so that first-party claimants can comply with policy conditions. Compliance with this paragraph within 30 days of notification of a claim shall constitute compliance with the above paragraph. See Or. Admin. R. 836-080-0225(4).

Also, insurers must make an appropriate reply within 30 days to all other pertinent communications from a claimant which reasonably suggest that a response is expected. See Or. Admin. R. 836-080-0225(3).

Prompt, Fair and Equitable Settlement of Claims

Under Oregon law, insurers must advise first-party claimants of the acceptance or denial of the claim within 30 days after receipt by the insurer of properly executed proofs of loss. A denial must be in writing and include reference to a specific policy provision. See Or. Admin. R. 836-080-0235(1).

If more time is needed to determine acceptance or denial, the insurer must notify the first-party claimant within 30 days after receipt of the proofs of loss, giving reasons more time is needed. See Or. Admin. R. 836-080-0235(4).

If the investigation remains incomplete, the insurer must send the claimant a letter 45 days from the date of initial notification and every 45 days thereafter, setting forth the reasons additional time is needed for investigation. See Or. Admin. R. 836-080-0235(4).
836-080-0225 Required Claim Communication Practices

An insurer shall:

1. Not later than the 30th day after receipt of notification of claim, acknowledge the notification or pay the claim. An appropriate and dated notation of the acknowledgment shall be included in the insurer's claim file.

2. Not later than the 21st day after receipt of an inquiry from the Director about a claim, furnish the Director with an adequate response.

3. Make an appropriate reply, not later than the 30th day after receipt, to all other pertinent communications about a claim from a claimant that reasonably indicate a response is expected.

4. Upon receiving notification of claim from a first party claimant, promptly provide necessary claim forms, instructions and assistance that is reasonable in the light of the information possessed by the insurer, so that the claimant can comply with the policy conditions and the insurer's reasonable requirements. Compliance with this section not later than the 30th day after receipt of notification of a claim constitutes compliance with section (1) of this rule.

836-080-0235 Standards for Prompt and Fair Settlements -- Generally

1. An insurer shall, not later than the 30th day after its receipt of properly executed proofs of loss from a first party claimant, advise the claimant of the acceptance or denial of the claim. An insurer shall not deny a claim on the grounds of a specific policy provision, condition or exclusion unless the denial includes reference to the provision, condition or exclusion. A claim denial must be in writing, with either a copy or the capability of reproducing its text included in the insurer's claim file.

2. If a claim is made on a health insurance policy and the claim involves a coordination of benefits issue to which OAR 836-020-0700 to 836-020-0765 apply, the time allowed in OAR 836-020-0740 to an insurer for applying a coordination of benefit provision shall added to the time period provided in section (1) of this rule.

3. If a claim is denied for reasons other than those described in section (1) of this rule and is made by any other means than in writing, an appropriate notation shall be made in the insurer's claim file.

4. If an insurer needs more time to determine whether the claim of a first party claimant should be accepted or denied, it shall so notify the claimant not later than the 30th day after receipt of the proofs of loss, giving the reason more time is needed. Forty-five days from the date of such initial
An insurer shall not fail to settle claims of first party claimants on the grounds that responsibility for payment should be assumed by others, except as may be provided otherwise by the provisions of the insurance policy issued by the insurer.

If an insurer continues 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 policy time limit, the insurer shall give the claimant written notice that the time limit may be expiring and may affect the claimant's rights. The notice shall be given to first party claimants not less than 30 days before, and to third party claimants not less than 60 days before, the date on which the insurer believes the time limit may expire.

An insurer shall not make a statement that indicates that the rights of a third party claimant may be impaired if a form or release is not completed within a given period of time, unless the statement is given for the purpose of notifying the third party claimant of the provision of a relevant statute of limitations.
Acknowledgment of Claim

Under Pennsylvania law, insurers must acknowledge the receipt of a notification of claim within 10 working days after receiving it, unless payment is made within that period of time. See 31 Pa. Code § 146.5(a).

Furthermore, insurers must provide first-party claimants with all necessary claim forms, instructions and reasonable assistance within 10 working days so that they can comply with the conditions of their policy. Compliance with this requirement within 10 working days of a notification of claim shall constitute compliance with subsection (a) above. See 31 Pa. Code § 146.5(d).

Also, insurers must reply within 10 working days to all other pertinent communications from a claimant which reasonably suggest that a response is expected. See 31 Pa. Code § 146.5(c).

Prompt, Fair and Equitable Settlement of Claims

Under Pennsylvania law, insurers must advise first-party claimants of the acceptance or denial of the claim within 15 working days after the receipt of properly executed proofs of loss. The requirements of this subsection do not apply when the claimant is suspected of fraud. See 31 Pa. Code § 146.7(a)(1) & (2).

If an insurer needs more time to determine whether a first-party claim should be accepted or denied, the insurer must notify the first-party claimant within 15 working days after receipt of the proofs of loss, giving reasons more time is needed. See 31 Pa. Code § 146.7(c)(1).

Furthermore, if the investigation remains incomplete, the insurer must send the claimant a letter 30 days from the date of initial notification and every 45 days thereafter, setting forth the reasons additional time is needed for investigation and stating when a decision on the claim may be expected. See 31 Pa. Code § 146.7(c)(1).
§ 146.5. Failure to acknowledge pertinent communications.

(a) Every insurer, upon receiving notification of a claim, shall, within 10 working days, acknowledge the receipt of the notice unless payment is made within the period of time. If an acknowledgment is made by means other than writing, an appropriate notation of the acknowledgment shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer, dating from the time the insurer receives notice.

(b) Every insurer, upon receipt of an inquiry from the Department respecting a claim shall, within 15 working days of receipt of the inquiry, furnish the Department with an adequate response to the inquiry.

(c) An appropriate reply shall be made within 10 working days on other pertinent communications from a claimant which reasonably suggest that a response is expected.

(d) Every insurer, upon receiving notification of claim, shall provide within 10 working days necessary claim forms, instructions and reasonable assistance so that first-party claimants can comply with the policy conditions and reasonable requirements of the insurer. Compliance with this subsection within 10 working days of notification of a claim shall constitute compliance with subsection (a).

§ 146.7. Standards for prompt, fair and equitable settlements applicable to insurers.

(a) Acceptance or denial of a claim shall comply with the following:

(1) Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. An insurer may not deny a claim on the grounds of a specific policy provision, condition or exclusion unless reference to the provision, condition or exclusion is included in the denial. The denial shall be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial.

(2) Where there is a reasonable basis supported by specific information available for review by the insurance regulatory authority that the first-party claimant has fraudulently caused or contributed to the loss by arson or other illegal activity, the insurer is relieved from the requirements of this subsection; provided, however, that the claimant shall be advised of the acceptance or denial of the claim within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.
(b) If a claim is denied for reasons other than those described in subsection (a) and is made by any other means than writing, an appropriate notation shall be made in the claim file of the insurer.

(c) The following provisions govern acceptance or denial of a claim where additional time is needed to make a determination:

(1) If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the proofs of loss giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the date of the initial notification and every 45 days thereafter, send to the claimant a letter setting forth the reasons additional time is needed for investigation and state when a decision on the claim may be expected.

(2) Where there is a reasonable basis supported by specific information available for review by the insurance regulatory authority for suspecting that the first-party claimant has fraudulently caused or contributed to the loss by arson or other illegal activity, the insurer is relieved from the requirements of this subsection; provided, however, that the claimant shall be advised of the acceptance or denial of the claim by the insurer within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.

(d) Insurers may 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.

(e) Insurers may not continue negotiations for settlement of a claim directly with a claimant who is neither an attorney nor represented by an attorney until the rights of the claimant 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 rights of the claimant. The notice shall be given to first-party claimants 30 days, and to third-party claimants 60 days, before the date on which the time limit may expire.

(f) An insurer may 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 given period of time unless the statement is given for the purpose of notifying the third-party claimant of the provision of a statute of limitations.
Acknowledgment of Claim

Under Rhode Island law, certain practices committed by an insurer with respect to claims, if performed with such frequency as to indicate a general business practice are defined as unfair and deceptive practices and are prohibited. See R.I. Gen. Laws § 27-9.1-3.

One such practice is failing to respond to a claim within 30 days, unless the insured shall agree to a longer period. See R.I. Gen. Laws § 27-9.1-4(16).

Another such practice is failing to acknowledge and act with reasonable promptness upon pertinent communications with respect to claims arising under policies. See R.I. Gen. Laws § 27-9.1-4(2).

Furthermore, an insurer must provide forms necessary to present claims within 10 calendar days of a request with reasonable explanations regarding their use. See R.I. Gen. Laws § 27-9.1-4(13).

Prompt, Fair and Equitable Settlement of Claims

Under Rhode Island law, certain practices committed by an insurer with respect to claims, if performed with such frequency as to indicate a general business practice are defined as unfair and deceptive practices and are prohibited. See R.I. Gen. Laws § 27-9.1-3.

One such practice is failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under policies. See R.I. Gen. Laws § 27-9.1-4(3).

Another such practice is not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear. See R.I. Gen. Laws § 27-9.1-4(4).

When used in this chapter:

(1) "Director" means the director of business regulation;

(2) "Insured" means the party named on a policy or certificate as the individual with legal rights to the benefits provided by the policy;

(3) "Insurer" means any person, reciprocal exchange, inter-insurer, Lloyds insurer, fraternal benefit society, and any other legal entity engaged in the business of insurance, including insurance producers, adjusters and third party administrators. Insurer shall also mean a nonprofit hospital and/or medical service corporation, a nonprofit dental service corporation, a nonprofit optometric service corporation, a nonprofit legal service corporation, a health maintenance organization as defined in chapter 41 of this title or as defined in chapter 62 of title 42, or any other entity providing a plan of health benefits subject to state insurance regulation. Notwithstanding §§ 27-19-2, 27-20-2, 27-20.1-2, 27-20.2-2, 27-20.3-2, and 27-41-22, for purposes of this chapter, these entities shall be deemed to be engaged in the business of insurance;

(4) "Person" means any natural or artificial entity, including, but not limited to, individuals, partnerships, associations, trusts, or corporations; and

(5) "Policy" or "certificate" means any contract of insurance, indemnity, medical, health or hospital service, or annuity issued. "Policy" or "certificate" for the purposes of this chapter shall not mean contracts or workers' compensation, fidelity, suretyship or boiler and machinery insurance.


It is an improper claims practice for any domestic, foreign, or alien insurer transacting business in this state to commit any act defined in § 27-9.1-4 of this chapter if:

(1) It is committed flagrantly and in conscious disregard of this chapter or any rules promulgated pursuant to this chapter; or

(2) It has been committed with a frequency as to indicate a general business practice to engage in that type of conduct.


Any of the following acts by an insurer, if committed in violation of § 27-9.1-3, constitutes an unfair claims practice:

(1) Misrepresenting to claimants and insured relevant facts or policy provisions relating to coverage at issue;
(2) Failing to acknowledge and act with reasonable promptness upon pertinent communications with respect to claims arising under its policies;

(3) Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies;

(4) Not attempting in good faith to effectuate prompt, fair, and equitable settlement of claims submitted in which liability has become reasonably clear;

(5) Compelling insured, beneficiaries, or claimants to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them;

(6) Refusing to pay claims without conducting a reasonable investigation;

(7) Failing to affirm or deny coverage of claims within a reasonable time after having completed its investigation related to the claim or claims;

(8) Attempting to settle or settling claims for less than the amount that a reasonable person would believe the insured or beneficiary was entitled by reference to written or printed advertising material accompanying or made part of an application;

(9) Attempting to settle or settling claims on the basis of an application that was materially altered without notice to, or knowledge or consent of, the insured;

(10) Making claims payments to an insured or beneficiary without indicating the coverage under which each payment is being made;

(11) Unreasonably delaying the investigation or payment of claims by requiring both a formal proof of loss form and subsequent verification that would result in duplication of information and verification appearing in the formal proof of loss form;

(12) Failing in the case of claims denials or offers of compromise settlement to promptly provide a reasonable and accurate explanation of the basis of those actions;

(13) Failing to provide forms necessary to present claims within ten (10) calendar days of a request with reasonable explanations regarding their use;

(14) Failing to adopt and implement reasonable standards to assure that the repairs of a repairer owned by or required to be used by the insurer are performed in a workmanlike manner;

(15) Misleading a claimant as to the applicable statute of limitations;

(16) Failing to respond to a claim within thirty (30) days, unless the insured shall agree to a longer period;

(17) Engaging in any act or practice of intimidation, coercion, threat or misrepresentation of consumers rights, for or against any insured person or entity to use a particular rental car company for motor vehicle replacement services or products; provided, however, nothing shall prohibit any insurance company, agent or adjuster from providing to such insured person or entity the names of a rental car company with which arrangements have been made with respect to motor vehicle replacement services; provided, that the rental car company is licensed pursuant to Rhode Island general laws § 31-5-33; or

(18) Refusing to honor a “direction to pay” executed by an insured indicating that the insured wishes to have the insurance company directly pay his or her motor vehicle replacement vehicle rental benefit to the rental car company of the consumer’s choice; provided, that the rental car company is licensed pursuant to Rhode Island general laws § 31-5-33. Nothing in this section shall be construed to prevent the insurance company’s ability to question or challenge the amount
charged, in accordance with its policy provisions, and the requirements of the department of business regulation.
SOUTH CAROLINA

Acknowledgment of Claim

Under South Carolina law, certain practices committed by an insurer with respect to claims, if performed with such frequency as to indicate a general business practice, are defined as unfair and deceptive practices and are prohibited. See S.C. Code Ann. § 38-59-20.

One such practice is failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under policies. See S.C. Code Ann. § 38-59-20(2).

Furthermore, when an insurer requires a written proof of loss after the notice of the loss has been given by the insured or beneficiary, the insurer must furnish a blank to be used for that purpose within 20 days. If the forms are not furnished within 20 days after receipt of the notice, the claimant is considered to have complied with the requirements of the policy as to proof of loss. See S.C. Code Ann. § 38-59-10.

Prompt, Fair and Equitable Settlement of Claims

Under South Carolina law, certain practices committed by an insurer with respect to claims, if performed with such frequency as to indicate a general business practice, are defined as unfair and deceptive practices and are prohibited. See S.C. Code Ann. § 38-59-20.

One such practice is failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under policies. See S.C. Code Ann. § 38-59-20(3).

Another such practice is not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear. See S.C. Code Ann. § 38-59-20(4).

Any of the following acts by an insurer doing accident and health insurance, property insurance, casualty insurance, surety insurance, marine insurance, or title insurance business, if committed without just cause and performed with such frequency as to indicate a general business practice, constitutes improper claim practices:

1. Knowingly misrepresenting to insureds or third-party claimants pertinent facts or policy provisions relating to coverages at issue or providing deceptive or misleading information with respect to coverages.

2. Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies, including third-party claims arising under liability insurance policies.

3. Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims, including third-party liability claims, arising under its policies.

4. Not attempting in good faith to effect prompt, fair, and equitable settlement of claims, including third-party liability claims, submitted to it in which liability has become reasonably clear.

5. Compelling policyholders or claimants, including third-party claimants under liability policies, to institute suits to recover amounts reasonably due or payable with respect to claims arising under its policies by offering substantially less than the amounts ultimately recovered through suits brought by the claimants or through settlements with their attorneys employed as the result of the inability of the claimants to effect reasonable settlements with the insurers.

6. Offering to settle claims, including third-party liability claims, for an amount less than the amount otherwise reasonably due or payable based upon the possibility or probability that the policyholder or claimant would be required to incur attorneys’ fees to recover the amount reasonably due or payable.

7. Invoking or threatening to invoke policy defenses or to rescind the policy as of its inception, not in good faith and with a reasonable expectation of prevailing with respect to the policy defense or attempted rescission, but for the primary purpose of discouraging or reducing a claim, including a third-party liability claim.

8. Any other practice which constitutes an unreasonable delay in paying or an unreasonable failure to pay or settle in full claims, including third-party liability claims, arising under coverages provided by its policies.

§ 38-59-10. Proof of loss forms required to be furnished.

When an insurer under an insurance policy requires a written proof of loss after the notice of the loss has been given by the insured or beneficiary, the insurer or its representative shall furnish a blank to be used for that purpose. If the forms are not furnished within twenty days after the receipt of the notice, the
claimant is considered to have complied with the requirements of the policy as to proof of loss upon submitting within the time fixed in the policy for filing proofs of loss written proof covering the occurrence, character, and extent of the loss for which claim is made. The twenty-day period after notice of loss to furnish forms applies to all types of insurance unless a lesser time period is specifically provided by law.
SOUTH DAKOTA

Acknowledgment of Claim

Under South Dakota law, certain practices by an insurer in dealing with insured are considered unfair and deceptive, and are prohibited. See S.D. Codified Laws § 58-33-67.

One such practice by an insurer is failing to acknowledge and act within 30 days upon receipt of communications with respect to claims arising under insurance policies. See S.D. Codified Laws § 58-33-67(1).

Prompt, Fair and Equitable Settlement of Claims

Under South Dakota law, certain practices by an insurer in dealing with insured are considered unfair and deceptive, and are prohibited. See S.D. Codified Laws § 58-33-67.

One such practice by an insurer is failing to adopt and adhere to reasonable standards for the prompt investigation of claims. See S.D. Codified Laws § 58-33-67(1).

Another such practice by an insurer is failing to promptly provide a reasonable explanation of the basis of a denial of a claim. See S.D. Codified Laws § 58-33-67(3).
58-33-67. Unfair or deceptive practices in dealing with insured

In dealing with the insured or representative of the insured, unfair or deceptive acts or practices in the business of insurance include, but are not limited to, the following:

1. Failing to acknowledge and act within thirty days upon communications with respect to claims arising under insurance policies and to adopt and adhere to reasonable standards for the prompt investigation of such claims;

2. Making claims payments to any claimant, insured, or beneficiary not accompanied by a statement setting forth the coverage under which the payments are being made;

3. 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;

4. Failing to promptly settle claims, where liability has become reasonably clear under one portion of the insurance policy coverage to influence settlements under other portions of the insurance policy coverage;

5. Requiring as a condition of payment of a claim that repairs to any damaged vehicle shall be made by a particular contractor or repair shop;

6. Failing to make a good faith assignment of the degree of contributory negligence in ascertaining the issue of liability;

7. Unless permitted by law and the insurance policy, refusing to settle a claim of an insured or claimant on the basis that the responsibility should be assumed by others.
Acknowledgment of Claim

Under Tennessee law, certain practices by insurers are considered unfair, and if committed with such frequency as to indicate a general business practice, are prohibited. See Tenn. Code Ann. § 56-8-104(8)(A).

An example of such an act is an insurer failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies. See Tenn. Code Ann. § 56-8-104(8)(A)(ii).

Prompt, Fair and Equitable Settlement of Claims

Under Tennessee law, certain practices by insurers are considered unfair, and if committed with such frequency as to indicate a general business practice, are prohibited. See Tenn. Code Ann. § 56-8-104(8)(A).

An example of such an act is an insurer failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed. See Tenn. Code Ann. § 56-8-104(8)(A)(iii).

Another example of such an act is an insurer not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear. See Tenn. Code Ann. § 56-8-104(8)(A)(x).
§ 56-8-104. Unfair competition or deceptive acts or practices

The following are hereby specifically defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance: . . .

(8) UNFAIR CLAIM SETTLEMENT PRACTICES.

(A) Subject to the conditions set forth in subdivision (8)(B), knowingly committing or performing any of the following acts with such frequency as to indicate, in the opinion of the commissioner, a general business practice; provided, that the commissioner shall have sole enforcement authority for this subdivision (8) and, notwithstanding any other laws of this state, a private right of action shall not be maintained under this subdivision (8):

(i) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

(ii) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

(iii) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(iv) Offering substantially less than the amounts ultimately recovered in actions brought by such insureds; provided, that equal consideration shall be given to the relationship between the amounts claimed and the amounts ultimately recovered through litigation;

(v) Attempting to settle a claim for less than the amount to which a reasonable person would have believed such person was entitled by reference to written or printed advertising material accompanying or made part of an application;

(vi) Attempting to settle claims on the basis of an application which was altered without notice to or knowledge or consent of the insured;

(vii) Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

(viii) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information; provided, that nothing herein is intended to prevent or discourage an insurer from requiring a sworn proof of loss when in its judgment such is necessary in order to establish either the liability or amount to which a claimant is entitled:
(ix) 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;

(x) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear; or

(xi) Failing to make payment of workers’ compensation benefits as such payment is required by the commissioner of the department of labor and workforce development or by title 50, chapter 6.

(B) Nothing contained in subdivision (8)(A) shall be construed as obligating any insurer to make a decision upon any claim without sufficient investigation and information to determine if such claim, or any part thereof, is false, fraudulent or for an excessive amount;
Acknowledgment of Claim

Under Texas law, no insurer shall engage in unfair claim settlement practices. Unfair claim settlement practices means, among other things, failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies. An acknowledgment within 15 business days is presumed to be reasonably prompt. See 28 Tex. Admin. Code § 21.203(2).

Prompt, Fair and Equitable Settlement of Claims


Unfair claim settlement practice also means not attempting in good faith to effectuate prompt, fair and equitable settlements of claims submitted in which liability has become reasonably clear. See 28 Tex. Admin. Code § 21.203(4).

Unfair claim settlement practice also means failing to provide promptly, when provided for in the policy, claims forms when the insurer requires such forms as a prerequisite for claim settlement. See 28 Tex. Admin. Code § 21.203(7).

Unfair claim settlement practice also means failing to affirm or deny coverage of a claim to a policyholder within a reasonable time. The submission of a reservation of rights letter by an insurer to a policyholder within a reasonable time is deemed compliance with the provisions of this paragraph. See 28 Tex. Admin. Code § 21.203(10).
§ 21.203. Unfair Claim Settlement Practices

No insurer shall engage in unfair claim settlement practices. Unfair claim settlement practices means committing or performing any of the following:

(1) misrepresenting to claimants pertinent facts or policy provisions relating to coverages at issue;

(2) failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies, provided that 'pertinent communications' shall exclude written communications that are direct responses to specific inquiries made by the insurer after initial report of a claim. An acknowledgment within 15 business days is presumed to be reasonably prompt;

(3) failing to adopt and implement reasonable standards for prompt investigation of claims arising under its policies;

(4) not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims submitted in which liability has become reasonably clear;

(5) compelling policyholders to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them;

(6) failure of any insurer to maintain, in substantial compliance with §21.2504 of this title (relating to Complaint Record; Required Elements; Explanation and Instructions), a complete record of all complaints, as that term is defined in §21.202(4) of this title (relating to Definitions), which it has received during the preceding three years or since the date of its most recent financial examination by the commissioner of insurance, whichever time is shorter. For purposes of this section, 'substantial compliance' has the meaning set out in §21.2503 of this title (relating to Compliance Standard);

(7) failing to provide promptly, when provided for in the policy, claim forms when the insurer requires such forms as a prerequisite for a claim settlement;

(8) not attempting in good faith to settle promptly claims where liability has become reasonably clear under one portion of the policy in order to influence settlement under other portions of the policy coverage. (This provision does not apply to those situations where payment under one portion of coverage constitutes evidence of liability under another portion of coverage);

(9) failing to provide promptly to a policyholder 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;
(10) failing to affirm or deny coverage of a claim to a policyholder within a reasonable time. The reasonable submission of a reservation of rights letter by an insurer to a policyholder within a reasonable time is deemed compliance with the provisions of this paragraph;

(11) except as may be specifically provided in the policy, to refuse, fail, or unreasonably delay offer of settlement under applicable first-party coverage on the basis that other coverage may be available or third parties are responsible in law for damages suffered;

(12) attempting to settle a claim for less than the amount to which a reasonable person would have believed she/he was entitled by reference to an advertisement, as described in §21.102 of this title (relating to Scope), made by an insurer or person acting on behalf of an insurer;

(13) undertaking to enforce a full and final release from a policyholder when, in fact, only a partial payment has been made. (This provision shall not prevent or have application to the compromise settlement of doubtful or disputed claims);

(14) failing to establish a policy and proper controls to make certain that agents calculate and deliver to policyholders or their assignees funds due under policy provisions relative to cancellation of coverage within a reasonable time after such coverages are terminated;

(15) refusing to pay claims without conducting a reasonable investigation based upon all available information;

(16) failing to respond promptly to a request by a claimant for personal contact about or review of the claim;

(17) with respect to the Texas personal auto policy, to delay or refuse settlement of a claim solely because there is other insurance of a different type available to satisfy partially or entirely the loss forming the basis of that claim. The claimant who has a right to recover from either or both insurers is entitled to choose under which coverage and in what order payment is to be made;

(18) a violation of the Insurance Code, Article 21.55, by an insurer subject to its provisions;

(19) requiring a claimant, as a condition of settling a claim, to produce the claimant's federal income tax returns for examination or investigation by the insurer unless the claimant is ordered to produce those tax returns by a court of competent jurisdiction, the claim involves a fire loss, or the claim involves a loss of profits or income.
Acknowledgment of Claim

Under Utah law, an insurer must acknowledge the receipt of a notification of claim within 15 days after receiving it, unless payment is made within such period of time, or unless the insurer has a reason acceptable to the Insurance Department as to why such acknowledgment cannot be made within the time specified. See Utah Admin. Code R590-190-6(1).

Furthermore, insurers must provide within 15 days all necessary claim forms, instructions, and reasonable assistance so that first-party claimants can comply with policy conditions and the insurer’s reasonable requirements. See Utah Admin. Code R590-190-6(3).

Also, insurers must provide a substantive response to a claimant within 15 days whenever a response has been requested. See Utah Admin. Code R590-190-6(2).

Prompt, Fair and Equitable Settlement of Claims

Under Utah law, an insurer must complete its investigation of claim and advise first-party claimants of the acceptance or denial of the claim within 30 days after receipt by the insurer of properly executed proofs of loss. See Utah Admin. Code R590-190-10(2).

If more time is needed to determine acceptance or denial, the insurer must notify the first-party claimant within 30 days after receipt of proofs of loss, giving reasons more time is needed. See Utah Admin. Code R590-190-10(2).

If the investigation remains incomplete, the insurer must send the claimant a letter 45 days from the date of initial notification and every 45 days thereafter, setting forth the reasons additional time is needed for investigation, unless the first-party claimant is represented by legal counsel or public adjuster. See Utah Admin. Code R590-190-10(2).

R590-190-1. Authority.
This rule is promulgated pursuant to Subsections 31A-2-201(1) and 31A-2-201(3)(a) in which the commissioner is empowered to administer and enforce this title and to make rules to implement the provisions of this title. Further authority to provide for timely payment of claims is provided by Subsection 31A-26-301(1). Matters relating to proof and notice of loss are promulgated pursuant to Section 31A-26-301 and Subsection 31A-21-312(5). Authority to promulgate rules defining unfair claims settlement practices or acts is provided in Subsection 31A-26-303(4). The authority to require a timely response to the Insurance Department is provided in Section 31A-2-202(4).

R590-190-2. Purpose.
This rule sets forth minimum standards for the investigation and disposition of property, liability, and title claims arising under contracts or certificates issued to residents of the State of Utah. It is not intended to cover bail bonds. These standards include fair and rapid settlement of claims, protection for claimants under insurance policies from unfair claims adjustment practices and promotion of professional competence of those engaged in claim adjusting. This rule defines procedures and practices which constitute unfair claim practices. This rule is regulatory in nature and is not intended to create any private right of action.

R590-190-3. Definitions.
For the purpose of this rule the commissioner adopts the definitions as set forth in 31A-1-301, and the following:

(1) "Claim file" means any record either in its original form or as recorded by any process which can accurately and reliably reproduce the original material regarding the claim, its investigation, adjustment and settlement.

(2) "Claimant" means either a first party claimant, a third party claimant, or both and includes such claimant's designated legal representative and includes a member of the claimant's immediate family designated by the claimant.

(3) "Claim representative" means any individual, corporation; association, organization, partnership, or other legal entity authorized to represent an insurer with respect to a claim, whether or not licensed within the State of Utah to do so.

(4) "Days" means calendar days.
(5) “Documentation” includes, but is not limited to, any pertinent communications, transactions, notes, work papers, claim forms, bills, and explanation of benefits forms relative to the claim.

(6) “First party claimant” means an individual, corporation, association, partnership or other legal entity asserting a right to a benefit or a payment under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by such policy or contract and includes such claimant's designated legal representative and includes a member of the claimant's immediate family designated by the claimant.

(7) “General business practice” means a pattern of conduct.

(8) “Investigation” means all activities of an insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy or insurance contract.

(9) “Notice of claim or loss” means any notification, whether in writing or other means acceptable under the terms of an insurance policy or insurance contract, to an insurer or its agent, by a claimant, which reasonably apprizes the insurer of the facts pertinent to a claim.

(10) “Proof of loss” shall mean reasonable documentation by the insured in accordance with policy provisions and insurer practices as to the facts of the loss and the amount of the claim.

(11) “Specific disclosure” shall mean notice to the insured by means of policy provisions in boldface type or a separate written notice mailed or delivered to the insured.

(12) “Third party claimant” means any person asserting a claim against any person under a policy or certificate of an insurer.

R590-190-4. File and Record Documentation.

Each insurer's claim files for policies or certificates are subject to examination by the commissioner of insurance or by the commissioner's duly appointed designees. To aid in such examination:

(1) the insurer shall maintain claim data that is accessible and retrievable for examination; and

(2) detailed documentation shall be contained in each claim file to permit reconstruction of the insurer's activities relative to the claim.


(1) The insurer and its representatives shall 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, including loss of use and household services.

(2) The insurer is prohibited from denying a claim based upon a first party claimant's failure to exhibit the property unless there is documentation of a breach of the policy provision in the claim file.
R590-190-6. Failure to Acknowledge Pertinent Communications.

Within 15-days every insurer shall:

(1) upon receiving notification of a claim, acknowledge the receipt of such notice unless payment is made within such period of time, or unless the insurer has a reason acceptable to the Insurance Department as to why such acknowledgment cannot be made within the time specified. Notice given to an agent of an insurer is notice to the insurer;

(2) provide a substantive response to a claimant whenever a response has been requested; and

(3) upon receiving notification of a claim, provide all necessary claim forms, instructions, and reasonable assistance so that first party claimants can comply with the policy conditions and the insurer’s reasonable requirements.

R590-190-7. Notice of Claim or Loss.

(1) Notice of Claim or Loss to an insurer, if required, shall be considered timely if made according to the terms of the policy, subject to the definitions and provisions of this rule, and the provisions of Section 31A-21-312.

(2) Notice of Claim or Loss may be given by an insured to any appointed agent, authorized adjuster, or other authorized claim representative of an insurer unless the insurer clearly directs otherwise by means of Specific Disclosure as defined herein.

(3) The general practice of the insurer when accepting a notice of loss or notice of claim shall be consistent for all policyholders in accordance with the terms of the policy.


Proof of loss to an insurer, if required, shall be considered timely if made according to the terms of the policy, subject to the definitions and provisions of this rule and the requirements of Section 31A-21-312.


The commissioner, pursuant to Section 31A-26-303(4), hereby finds the following acts, or the failure to perform required acts, to be misleading, deceptive, unfairly discriminatory or overreaching in the settlement of claims:

(1) denying or threatening the denial of the payment of claims or rescinding, canceling or threatening the recission or cancellation of coverage under a policy for any reason which is not clearly described in the policy as a reason for such denial, cancellation or rescission;

(2) failing to provide the insured or beneficiary with a written explanation of the evidence of any
investigation or file materials giving rise to the denial of a claim based on misrepresentation or fraud on an insurance application, when such misrepresentation is the basis for the denial;

(3) compensation by an insurer of its employees, agents or contractors of any amounts which are based on savings to the insurer as a result of denying the payment of claims;

(4) failing to deliver a copy of the insurer's guidelines, which could include the department's statutes, rules and bulletins, for prompt investigation of claims to the Insurance Department when requested to do so;

(5) refusing to pay claims without conducting a reasonable investigation;

(6) offering first party claimants substantially less than the reasonable value of the claim. Such value may be established by one or more independent sources;

(7) making claim payments to insureds or beneficiaries not accompanied by a statement or explanation of benefits setting forth the coverage under which the payments are being made and how the payment amount was calculated;

(8) failing to pay claims within 30-days of properly executed proof of loss when liability is reasonably clear under one coverage in order to influence settlements under other portions of the insurance policy coverage or under other policies of insurance;

(9) refusing payment of a claim solely on the basis of an insured’s request to do so unless:

   (a) the insured claims sovereign, eleemosynary, diplomatic, military service, or other immunity from suit or liability with respect to such claim; or

   (b) the insured is granted the right under the policy of insurance to consent to settlement of claims.

(10) advising a claimant not to obtain the services of an attorney or suggesting the claimant will receive less money if an attorney is used to pursue or advise on the merits of a claim;

(11) misleading a claimant as to the applicable statute of limitations;

(12) requiring an insured to sign a release that extends beyond the occurrence or cause of action that gave rise to the claims payment;

(13) deducting from a loss or claim payment made under one policy those premiums owed by the insured on another policy, unless the insured consents;

(14) failing to settle a first party claim on the basis that responsibility for payment of the claim should be assumed by others, except as may otherwise be provided by policy provisions;
(15) issuing checks or drafts in partial settlement of a loss or a claim under a specified coverage when such check or draft contains language which purports to release the insurer or its insured from total liability;

(16) refusing to provide a written basis for the denial of a claim upon demand of the insured;

(17) denying a claim for medical treatment after preauthorization has been given, except in cases where the insurer obtains and provides to the claimant documentation of the pre-existence of the condition for which the preauthorization has been given or if the claimant is not eligible for coverage;

(18) refusing to pay reasonably incurred expenses to an insured when such expenses resulted from a delay, as prohibited by these rules, in claims settlement or claims payment;

(19) when an automobile insurer represents both a tortfeasor and a claimant:

(a) failing to advise a claimant under any coverage that the same insurance company represents both the tortfeasor and the claimant as soon as such information becomes known to the insurer; and

(b) allocating medical payments to the tortfeasor's liability coverage before exhausting a claimant's personal injury protection coverage.

(20) failing to pay interest at the legal rate, as provided in Title 15, Utah Code, upon amounts that are overdue under these rules. This does not apply to insurers who fail to pay Personal Injury Protection expenses when due. These expenses shall bear interest as provided in 31A-22-309(5)(c).

R590-190-10. Minimum Standards for Prompt, Fair and Equitable Settlements.

(1) The insurer shall provide to the claimant a statement of the time and manner in which any claim must be made and the type of proof of loss required by the insurer.

(2) Within 30-days after receipt by the insurer of a properly executed proof of loss, the insurer shall complete its investigation of the claim and the first party claimant shall be advised of the acceptance or denial of the claim by the insurer unless the investigation cannot be reasonably completed within that time. If the insurer needs more time to determine whether a first party claim should be accepted or denied, it shall so notify the first party claimant within 30-days after receipt of the proofs of loss, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, within 45-days after sending the initial notification and within every 45-days thereafter, send to the first party claimant a letter setting forth the reasons additional time is needed for the investigation, unless the first party claimant is represented by legal counsel or public adjuster. Any basis for the denial of a claim shall be noted in the insurers claim file and must be communicated promptly and in writing to the first party claimant. Insurers are prohibited from denying a claim on the grounds of a specific provision, condition, or exclusion unless reference to such provision, condition or exclusion is included in the denial.

(3) Unless otherwise provided by law, an insurer shall promptly pay every valid insurance claim. A claim shall be overdue if not paid within 30-days after the insurer is furnished written proof of the fact of a
covered loss and of the amount of the loss. Payment shall mean actual delivery or mailing of the amount owed. If such written proof is not furnished to the insurer as to the entire claim, any partial amount supported by written proof or investigation is overdue if not paid within 30-days. Payments are not deemed overdue when the insurer has reasonable evidence to establish that the insurer is not responsible for the payment, notwithstanding that written proof has been furnished to the insurer.

(4) If negotiations are continuing for settlement of a claim with a claimant, who is not represented by legal counsel or public adjuster, notice of expiration of the statute of limitation or contract time limit shall be given to the claimant at least 60 days before the date on which such time limit may expire.

(5) Insurers are prohibited from making statements which indicate that the rights of a third party claimant may be impaired if a form or release is not completed within a given period of time unless the statement is given for the purpose of notifying the third party claimant of the provision of a statute of limitations.

(6) Upon receipt of an inquiry from the insurance department regarding a claim, every licensee shall furnish a substantive response to the insurance department within the time period specified in the inquiry. . .
Acknowledgment of Claim

Under Vermont law, an insurer or its agent who has adjusting authority must mail or orally acknowledge receipt of a claim notice directly to the claimant within 10 working days. If made orally, a notation of the acknowledgment must be recorded in the insurer’s record or file. See Vt. Admin. Reg. 79-2 § 5(A).

An insurer must make appropriate written or oral reply within 10 working days to any communication from a claimant which specifically addresses itself to questions raised by the claimant. See Vt. Admin. Reg. 79-2 § 5(B).

Prompt, Fair and Equitable Settlement of Claims

Under Vermont law, insurers must advise first-party claimants of the acceptance or denial of the claim within 15 working days after receipt by the insurer of properly executed proofs of loss. A denial must be in writing and include reference to a specific policy provision. See Vt. Admin. Reg. 79-2 § 6(A).

If more time is needed to determine acceptance or denial, the insurer must notify the first-party claimant within 15 working days after receipt of the proofs of loss, giving reasons more time is needed. See Vt. Admin. Reg. 79-2 § 6(C).

If the investigation remains incomplete, the insurer must send the claimant a letter 30 days from the date of initial notification and ever 30 days thereafter, setting forth the reasons additional time is needed for investigation. This provision does not apply when the first-party claimant files suit or third party claimant employs legal counsel. See Vt. Admin. Reg. 79-2 § 6(C).
21 020 008. Fair Claims Practices Regulation

SECTION 1. AUTHORITY

8 V.S.A., Section 4724 of the Unfair Trade Practices Act prohibits insurers doing business in Vermont from engaging in unfair claims settlement practices and provides that if any insurer performs any of the acts or practices prescribed by that section with such frequency as to indicate a general business practice, such acts or practices shall constitute an unfair or deceptive act or practice in the business of insurance. Under such authority as is found in Section 4724 and also in Section 75 of Chapter 3 of 8 V.S.A., we promulgate this Regulation.

SECTION 2. PURPOSE

This Regulation is intended to supplement 8 V.S.A., Section 4724 for the purpose of protecting the interests of the public and to insure prompt and equitable claim handling by establishing minimum standards for all types of claim settlements.

SECTION 3. SCOPE

This Regulation defines certain minimum standards which, if violated with such frequency as to indicate a general business practice, will be deemed to constitute an unfair claim settlement practice. This Regulation applies to all persons and all insurance policies and contracts except policies of Workers’ Compensation, title insurance and surety. This Regulation is not exclusive, and any other acts, not herein specified, may also be deemed a violation of 8 V.S.A., Section 4724 of the Unfair Trade Practices Act.

SECTION 4. DEFINITIONS

The definitions of “person” and of “insurance policy or insurance contract” contained in 8 V.S.A., Section 4722 of the Unfair Trade Practices Act shall apply to this Regulation and, in addition, where used in this Regulation:

A. “Agent” means any individual, corporation, association, partnership, or other legal entity authorized to represent an insurer with respect to a claim;
B. “Claimant” means either a first party claimant, a third party claimant, or both and includes such claimant’s designated legal representative and any member of the claimant’s immediate family designated by the claimant;

C. “First Party Claimant” means an individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by such policy or contract;

D. “Third Party Claimant” means any individual, corporation, association, partnership or other legal entity asserting a claim against any individual, corporation, association, partnership or other legal entity insured under an insurance policy or insurance contract of an insurer;

E. “Insurer” means a person who issues any insurance policy or insurance contract in this State;

F. “Worker’s Compensation” includes, but is not limited to, Longshoremen’s and Harbor Worker’s Compensation;

G. “Fire Insurance Policy” means “The Standard Fire Insurance Policy”, combined with its related forms, but shall not include other policies containing the peril of fire, including, but not limited to, SMP, homeowners, inland marine or similar policies; and

H. “Investigation” means all activities of an insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy or insurance contract.

SECTION 5. NOTIFICATION TIME REQUIREMENTS

A. An insurer or its agent who has claim adjusting authority shall mail or orally acknowledge receipt of the claim notice directly to the claimant, within ten (10) working days. If the acknowledgment is made orally, notation of the acknowledgment shall be recorded in the insurer’s record or file.

B. An insurer shall make appropriate written or oral reply within ten (10) working days to any communication from claimant which specifically addresses itself to questions raised by claimant.

C. An insurer who receives an inquiry or complaint from the Department of Banking and Insurance shall furnish a response within fifteen (15) working days addressing itself to the specifics of the inquiry or complaint.

SECTION 6. TIME LIMIT FOR CLAIM SETTLEMENTS
A. Within fifteen (15) working days after receipt by the insurer of properly executed proofs of loss, the first party claimant shall be advised of the acceptance or denial of the claim by the insurer. No insurer shall deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to such provision, condition, or exclusion is included in the denial. The denial must be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial.

B. If a claim is denied for reasons other than those described in paragraph A, and is made by any other means than writing, an appropriate notation shall be made in the claim file of the insurer.

C. If the insurer needs more time to determine whether a first party claim should be accepted or denied, it shall so notify the first party claimant within fifteen (15) working days after receipt of the proofs of loss giving the reasons more time is needed. Claims governed by 8 V.S.A., Chapter 105, Section 3868, are excepted from this provision. If the insurer needs more time to determine whether a third party claim should be accepted or denied, it shall so notify the third party claimant within thirty (30) working days after receipt of notice of claim giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, thirty (30) working days from the date of the initial notification and every thirty (30) working days thereafter, send to such claimant a letter setting forth the reasons additional time is needed for investigation. The provisions of this section shall not apply upon filing of suit by first party claimant or employment of legal counsel by third party claimant.

D. Insurers shall not fail to settle first party claims on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions.

E. Insurers shall not continue negotiations for settlement of a claim directly with a claimant who is neither an attorney nor represented by an attorney until the claimant’s rights may be affected by a statute of limitations or a policy or contract time limit, without giving the claimant written notice that the time limit may be expiring and may affect the claimant’s rights. Such notice shall be given to first party claimants thirty (30) working days and to third party claimants sixty (60) working days before the date on which such time limit may expire.

F. No insurer shall make statements which indicate that the rights of a third party claimant may be impaired if a form or release is not completed within a given period of time unless the statement is given for the purpose of notifying the third party claimant of the provision of a statute of limitations.

G. After settlement has been agreed upon, insurer shall mail payment in amount agreed to claimant and/or loss payee within ten (10) working days, unless a further delay is mandated under an order by a court of competent jurisdiction or required by law.

SECTION 7. STANDARDS FOR FAIR & EQUITABLE SETTLEMENTS
A. If the insurer denies a claim in whole or in part, it shall provide claimant with appropriate reasons therefore, including reference to appropriate applicable policy provisions, conditions or exclusions.
B. All claim payments shall include an appropriate explanation of the basis of the payment (example, full explanation of all deductions for depreciations, deductibles or co-insurance).

C. All insurers who do not maintain a claims office or offices in Vermont shall provide claimant with toll-free or collect telephone number of the representative handling the claim for claimant’s retention.

D. Where liability has become reasonably clear, an insurer is prohibited from withholding payment under one portion of a liability claim in order to influence settlement of another portion of a liability claim. . .
Acknowledgment of Claim

Under Virginia law, an insurer must acknowledge the receipt of a notification of claim within 10 working days after receiving it, unless payment is made within such period of time. See 14 Va. Admin. Code § 5-400-50(A).

Furthermore, insurers must promptly provide all necessary claim forms, instructions, and reasonable assistance so that first-party claimants can comply with policy conditions. Compliance with this paragraph within 10 working days of notification of a claim shall constitute compliance with the above paragraph. See 14 Va. Admin. Code § 5-400-50(D).

Also, insurers must make an appropriate reply within 10 working days to all other pertinent communications from a claimant which reasonably suggest that a response is expected. See 14 Va. Admin. Code § 5-400-50(C).

Prompt, Fair and Equitable Settlement of Claims

Under Virginia law, insurers must advise first-party claimants of the acceptance or denial of the claim within 15 working days after receipt by the insurer of properly executed proofs of loss. A denial must be in writing and include reference to a specific policy provision. See 14 Va. Admin. Code § 5-400-60(A).

If more time is needed to determine acceptance or denial, the insurer must notify the first-party claimant within 15 working days after receipt of the proofs of loss, giving reasons more time is needed. See 14 Va. Admin. Code § 5-400-60(A).

If the investigation remains incomplete, the insurer must send the claimant a letter 45 days from the date of initial notification and ever 45 days thereafter, setting forth the reasons additional time is needed for investigation. See 14 Va. Admin. Code § 5-400-60(B).
14 VAC 5-400-20. Definitions.

The definition of "person" contained in § 38.2-501 of the Code of Virginia shall apply to this chapter and, in addition, where used in this chapter:

"Agent" means any individual, corporation, association, partnership or other legal entity authorized to represent an insurer with respect to a claim;

"Claim" means a demand for payment by a claimant and does not mean an inquiry concerning coverage;

"Claimant" means either a first party claimant, a third party claimant, or both, and includes such claimant's designated legal representative and includes a member of the claimant's immediate family designated by the claimant;

"Commission" means the State Corporation Commission of the Commonwealth of Virginia;

"First party claimant" means an individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy or insurance contract issued to such individual, corporation, association, partnership or other legal entity arising out of the occurrence of the contingency or loss covered by such policy or contract;

"Insurer" means a person licensed to issue or who issues any insurance policy or insurance contract in this Commonwealth and shall include surplus lines brokers;

"Investigation" means all activities of an insurer directly or indirectly related to the determination of liability and extent of loss under coverages afforded by an insurance policy or insurance contract;

"Notification of claim" means any notification, whether in writing or other means acceptable under the terms of the insurance policy or insurance contract, to an insurer or its agent, by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim;

"Third party claimant" means any individual, corporation, association, partnership or other legal entity asserting a claim against any individual, corporation, association, partnership or other legal entity insured under an insurance policy or insurance contract of an insurer;
"Workers' Compensation insurance" includes, but is not limited to, Longshoremen's and Harbor Workers' Compensation.

14 VAC 5-400-50. Failure to acknowledge pertinent communications.

A. Every insurer, upon receiving notification of a claim shall, within 10 working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgement shall be made in the claim file of the insurer and dated. Notification given by a claimant to an agent of an insurer shall be notification to the insurer.

B. Every insurer, upon receipt of any inquiry from the Commission respecting a claim shall, within 15 working days of receipt of such inquiry, furnish an adequate response to the inquiry.

C. An appropriate reply shall be made within 10 working days on all other pertinent communications from a claimant which reasonably suggest that a response is expected.

D. Every insurer, upon receiving notification of a first party claim, shall promptly provide necessary claim forms, instructions, and reasonable assistance so that first party claimants can comply with the policy conditions and the insurer's reasonable requirements; provided, however, every insurer, upon receiving notification of a third party claim, shall promptly provide the third party claimant with all necessary claim forms. Compliance with this subdivision within 10 working days of notification of a claim shall constitute compliance with subsection A of this section.

14 VAC 5-400-60. Standards for prompt investigation of claims.

A. Unless otherwise specified in the policy, within 15 working days after receipt by the insurer of properly executed proofs of loss, a first party claimant shall be advised of the acceptance or denial of the claim by the insurer. If the insurer needs more time to determine whether a first party claim should be accepted or denied, it shall notify the first party claimant within 15 working days after receipt of the proofs of loss giving the reasons more time is needed.

B. Unless otherwise specified in the policy, if an investigation of a first party claim has not been completed, every insurer shall, within 45 days from the date of the notification of a first party claim and every 45 days thereafter, send to the first party claimant a letter setting forth the reasons additional time is needed for investigation.
Acknowledgment of Claim

Under Washington law, insurers must acknowledge the receipt of a notification of claim within 10 working days after receiving it, unless payment is made within such period of time. See Wash. Admin. Code § 284-30-360(1).

Furthermore, insurers must promptly provide all necessary claim forms, instructions, and reasonable assistance so that the first-party claimants can comply with policy conditions. Compliance with this paragraph within 10 working days of notification of a claim shall constitute compliance with the above paragraph. See Wash. Admin. Code § 284-30-360(4).

Also, insurers must make an appropriate reply within 10 working days to all other pertinent communications from a claimant which reasonably suggest that a response is expected. See Wash. Admin. Code § 284-30-360(3).

Prompt, Fair and Equitable Settlement of Claims

Under Washington law, insurers must advise first-party claimants of the acceptance or denial of the claim within 15 working days after receipt by the insurer of properly executed proofs of loss. A denial must be in writing and include reference to a specific policy provision, and the insurer’s claim file must contain a copy of the denial. See Wash. Admin. Code § 284-30-380(1).

If more time is needed to determine acceptance or denial, the insurer must notify the first-party claimant within 15 working days after the receipt of the proofs of loss, giving reasons more time is needed. See Wash. Admin. Code § 284-30-380(3).

If the investigation remains incomplete, the insurer must send the claimant a letter 45 days from the date of initial notification and no later than every 30 days thereafter, setting forth the reasons additional time is needed for investigation. See Wash. Admin. Code § 284-30-380(3).

NOTE: Insurance Fair Conduct Act taking effect on a date to be announced will expand the range of claimants’ remedies for a proven statutory violation by an insurer.

When used in this regulation:

(1) "Agent" means any individual, corporation, association, partnership or other legal entity authorized to represent an insurer with respect to a claim;

(2) "Claimant" means either a first party claimant, a third party claimant, or both and includes such claimant's designated legal representative and includes a member of the claimant's immediate family designated by the claimant;

(3) "First party claimant" means an individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by such policy or contract;

(4) "Insurance policy" or "insurance contract" mean any contract of insurance, indemnity, suretyship, or annuity issued, proposed for issuance, or intended for issuance by any insurer;

(5) "Insurer" means any individual, corporation, association, partnership, reciprocal exchange, interinsurer, Lloyds insurer, fraternal mutual insurer, fraternal mutual life insurer, and any other legal entity engaged in the business of insurance, authorized or licensed to issue or who issues any insurance policy or insurance contract in this state. "Insurer" does not include health care service contractors, as defined in RCW 48.44.010, and health maintenance organizations, as defined in RCW 48.46.020;

(6) "Investigation" means all activities of an insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy or insurance contract;

(7) "Notification of claim" means any notification, whether in writing or other means acceptable under the terms of an insurance policy or insurance contract, to an insurer or its agent, by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim; and

(8) "Third party claimant" means any individual, corporation, association, partnership or other legal entity asserting a claim against any individual, corporation, association, partnership or other legal entity insured under an insurance policy or insurance contract of an insurer.

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 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 proof of loss statements have been completed.

(6) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear. In particular, this includes an obligation to effectuate prompt payment of property damage claims to innocent third parties in clear liability situations. If two or more insurers are involved, they should arrange to make such payment, leaving to themselves the burden of apportioning it.

(7) Compelling insureds to institute 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 man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application.

(9) Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which the payments are being made.

(10) Asserting to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

(11) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring subsequent submissions which contain substantially the same information.

(12) Failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

(13) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

(14) Unfairly discriminating against claimants because they are represented by a public adjuster.

(15) Failure to expeditiously honor drafts given in settlement of claims. A failure to honor a draft within three working days of notice of receipt by the payor bank will constitute a violation of this provision. Dishonor of any such draft for valid reasons related to the settlement of the claim will not constitute a violation of this provision.
(16) Failure to adopt and implement reasonable standards for the processing and payment of claims once the obligation to pay has been established. Except as to those instances where the time for payment is governed by statute or rule or is set forth in an applicable contract, procedures which are not designed to deliver a check or draft to the payee in payment of a settled claim within fifteen business days after receipt by the insurer or its attorney of properly executed releases or other settlement documents are not acceptable. Where the insurer is obligated to furnish an appropriate release or settlement document to an insured or claimant, it shall 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 an insured claimant to identify the claimant or to obtain details concerning the claim.

WAC 284-30-360. Failure to acknowledge pertinent communications.

(1) Every insurer, upon receiving notification of a claim shall, within ten working days, or 15 working days with respect to claims arising under group insurance contracts, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgement shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer.

(2) Every insurer, upon receipt of any inquiry from the office of the insurance commissioner respecting a claim shall, within fifteen working days of receipt of such inquiry, furnish the department with an adequate response to the inquiry.

(3) An appropriate reply shall be made within ten working days, or 15 working days with respect to communications arising under group insurance contracts, on all other pertinent communications from a claimant which reasonably suggest that a response is expected.

(4) Every insurer, upon receiving notification of claim, shall promptly provide necessary claim forms, instructions, and reasonable assistance so that first party claimants can comply with the policy conditions and the insurer’s reasonable requirements. Compliance with this paragraph within the time limits specified in subsection (1) of this section shall constitute compliance with that subsection.

WAC 284-30-370. Standards for prompt investigation of claims.

Every insurer shall complete investigation of a claim within thirty days after notification of claim, unless such investigation cannot reasonably be completed within such time. All persons involved in the investigation of a claim shall provide reasonable assistance to the insurer in order to facilitate compliance with this provision.
WAC 284-30-380. Standards for prompt, fair and equitable settlements applicable to all insurers.

(1) Within fifteen working days after receipt by the insurer of properly executed proofs of loss, the first party claimant shall be advised of the acceptance or denial of the claim by the insurer. No insurer shall deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to such provision, condition, or exclusion is included in the denial. The denial must be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial.

(2) If a claim is denied for reasons other than those described in subsection (1) and is made by any other means than writing, an appropriate notation shall be made in the claim file of the insurer.

(3) If the insurer needs more time to determine whether a first party claim should be accepted or denied, it shall so notify the first party claimant within fifteen working days after receipt of the proofs of loss giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, within forty-five days from the date of the initial notification and no later than every thirty days thereafter, send to such claimant a letter setting forth the reasons additional time is needed for investigation.

(4) Insurers shall not fail to settle first party claims on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions.

(5) Insurers shall not continue negotiations for settlement of a claim directly with a claimant who is neither an attorney nor represented by an attorney until the claimant’s rights may be affected by a statute of limitations or a policy or contract time limit, without giving the claimant written notice that the time limit may be expiring and may affect the claimant’s rights. Such notice shall be given to first party claimants thirty days and to third party claimants sixty days before the date on which such time limit may expire.

(6) No insurer shall make statements which indicate that the rights of a third party claimant may be impaired if a form or release is not completed within a given period of time unless the statement is given for the purpose of notifying the third party claimant of the provision of a statute of limitations.
WEST VIRGINIA

Acknowledgment of Claim

Under West Virginia law, insurers must acknowledge the receipt of a notification of claim within 15 working days after receiving it, unless payment is made within such period of time. If acknowledgment is made by means other than writing, a notation shall be made in the insurer’s claim file and dated. See W. Va. Code St. R. § 114-14-5.1.

Furthermore, insurers must promptly provide all necessary claim forms, instructions, and reasonable assistance so that first-party claimants can comply with policy conditions. Compliance with this paragraph within 15 working days of notification of a claim shall constitute compliance with the above paragraph. See W. Va. Code St. R. § 114-14-5.4.

Also, insurers must make an appropriate reply within 15 working days to all other pertinent communications from a claimant which reasonably suggest that a response is expected. See W. Va. Code St. R. § 114-14-5.3.

Prompt, Fair and Equitable Settlement of Claims

Under West Virginia law, insurers must establish procedures to commence an investigation of any claim within 15 working days after receipt of the notification of claim. See W. Va. Code St. R. § 114-14-6.2(a).

If more time is needed to determine acceptance or denial, the insurer must notify the first-party claimant within 15 working days after the expiration of 30 calendar days after receipt of the proofs of loss, giving reasons more time is needed. See W. Va. Code St. R. § 114-14-6.7.

If the investigation remains incomplete, the insurer must send the claimant a letter every 45 days setting forth the reasons additional time is needed for investigation. Insurers are relieved of the requirements of this paragraph if there is reasonable basis for belief of fraud by the claimant. See W. Va. Code St. R. § 114-14-6.7.
§ 114-14-5. Standards For The Acknowledgment Of Pertinent Communications.

5.1. Acknowledgment of notices of claims.

Every insurer, upon receiving notification of a claim shall, within fifteen (15) working days, acknowledge the receipt of such notice unless full payment is made within such period of time. If an acknowledgment is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer.

5.2. Answer of inquiries from Insurance Commissioner.

Every insurer, producer or other licensee, upon receipt of any inquiry other than a notice of third-party administrative complaint from the Insurance Commissioner shall, within fifteen (15) working days of the date appearing on the inquiry, furnish the Commissioner with a complete written response to the inquiry. A "complete written response" addresses all issues raised by the claimant or the Commissioner and includes copies of any documentation requested. This subsection is not intended to permit delay in responding to inquiries by the Commissioner or his or her staff in conjunction with a scheduled examination on the insurer's premises.

5.3. Replies to other pertinent communications.

A reply shall be made within fifteen (15) working days of receipt by the insurer to all other pertinent communications from a claimant which reasonably suggest that a response is expected.

5.4. Provisions of assistance to first-party claimants.

Every insurer, upon receiving notification of a claim, shall promptly provide necessary claim forms, instructions, and reasonable assistance so that first-party claimants can comply with the policy conditions and the insurer's reasonable requirements. Compliance with this subsection within fifteen (15) working days of notification of a claim constitutes compliance with subsection 5.1. of this section.

§ 114-14-6. Standards For Prompt Investigations And Fair And Equitable Settlements Applicable To All Insurers.

6.1. Investigation of claims.

Every insurer shall promptly conduct and diligently pursue a thorough, fair and objective investigation
and may not unreasonably delay resolution by persisting in seeking information not reasonably required for or material to the resolution of a claim dispute. This section is not intended to conflict with the statutory requirements of the Medical Professional Liability Act, W. Va. Code § § 55-7B-1 to 11, as the same relate to the assertion and investigation of medical professional liability claims.

6.2. Establishment of investigatory procedures.

a. Every insurer shall establish procedures to commence an investigation of any claim filed by a claimant, or by a claimant’s authorized representative, within fifteen (15) working days of receipt of notice of claim.

b. Every insurer shall provide to every first-party claimant, or to the claimant’s authorized representative, a notification of all items, statements and forms, if any, which the insurer reasonably believes will be required of such claimant, within fifteen (15) working days of receiving notice of the claim.

c. A claim filed with an agent of an insurer shall be deemed to have been filed with the insurer unless, consistent with law or contract, such agent promptly provides written notification to the person filing the claim that the agent is not authorized to receive notices of claim.

6.3. Duty after investigation.

Within ten (10) working days of completing its investigation, the insurer shall deny the claim in writing or make a written offer, subject to policy limits and, with respect to medical professional liability claims, subject to applicable statutory requirements set forth in the Medical Professional Liability Act, W. Va. Code § § 55-7B-1 to 11.

6.4. Offers of settlement.

a. In any case where there is no dispute as to coverage and liability, it is the duty of every insurer to offer claimants or their authorized representatives, amounts which are fair and reasonable, as shown by the insurer’s investigation of the claim, providing the amounts so offered are within policy limits and in accordance with the policy provisions.

b. No insurer may attempt to settle a claim by making a settlement offer that is unreasonably low. The Commissioner shall consider any evidence offered regarding the following factors in determining whether a settlement offer is unreasonably low:

1. The extent to which the insurer considered evidence submitted by the claimant to support the value of the claim;

2. the extent to which the insurer considered legal authority or evidence made known to it or reasonably available;

3. The extent to which the insurer considered the advice of its claims adjuster as to the amount of damages;

4. The extent to which the insurer considered the opinions of independent experts;

5. The procedures used by the insurer in determining the dollar amount of property damage;

6. The extent to which the insurer considered the probable liability of the insured and the likely jury verdict or other final determination of the matter; and

7. Any other credible evidence presented to the Commissioner that demonstrates that the final amount
offered in settlement of the claim by the insurer is or is not below the amount that a reasonable person would have offered in settlement of the claim after taking into consideration the relevant facts and circumstances at the time the offer was made.

6.5. Denial of claims.

No insurer may deny a claim on the grounds of a specific policy provision, condition or exclusion unless reference to such provision, condition or exclusion is included in the denial. The denial must be given to the claimant in writing or as otherwise provided in subsection 6.6. of these rules.

6.6. Records of denial of claims.

If a denial of a claim is made by any other means than writing, an appropriate notation shall be made in the claim file of the insurer.

6.7. Notice of necessary delay in investigating claims.

If the insurer needs more than thirty (30) calendar days from the date that a proof of loss from a first-party claimant or notice of claim from a third-party claimant is received to determine whether a claim should be accepted or denied, it shall so notify the claimant in writing within fifteen (15) working days after the thirty-day period expires. If the investigation remains incomplete, the insurer shall provide written notification of the delay to the claimant every forty-five (45) calendar days thereafter until the investigation is complete. All such notifications must set forth the reason(s) additional time is needed for investigation. Where there is a reasonable basis supported by specific information available for review by the Commissioner that a claimant has fraudulently caused or contributed to the loss, the insurer is relieved from the requirements of this subsection: Provided, That the insurer shall notify the claimant of the acceptance or denial of the claim within a reasonable time allowing for full investigation. Nothing contained in this subsection requires an insurer to disclose any information that could reasonably be expected to alert a claimant to the fact that the subject claim is being investigated as a suspected fraudulent claim.

6.8. Liability of others.

Insurers may not refuse 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.

6.9. Denial of claims for failure to exhibit property.

No insurer may deny a claim for failure to exhibit the insured property without proof of demand by the insurer and refusal by the claimant to exhibit said property.

6.10. Separation of claims.

In any case where there is no dispute as to one (1) or more elements of a claim, payment for such element(s) shall be made notwithstanding the existence of disputes as to other elements of the claim where such payment can be made without prejudice to either party.

6.11. Time for payment of claims.

Every insurer shall pay any amount finally agreed upon in settlement of all or part of any claim not later than fifteen (15) working days from the receipt of such agreement by the insurer or from the date of the performance by the claimant of any condition set by such agreement, whichever is later.

No person may negotiate for settlement of a claim with a claimant who is neither an attorney nor represented by an attorney without giving the claimant written notice that the claimant’s rights may be affected by a statute of limitations or a policy or contract time limit. Such notice shall be given to first-party claimants not less than thirty (30) days, and to third-party claimants not less than sixty (60) days, before the date on which such time limit expires.
Acknowledgment of Claim

Under Wisconsin law, certain acts by the insurer if committed with such frequency as to indicate a general business practice, shall constitute unfair methods and practices in the business of insurance. See Wis. Admin. Code Ins. § 6.11(3).

An example of unfair acts by an insurer is the failure to promptly acknowledge pertinent communications with respect to claims arising under insurance policies. See Wis. Admin. Code Ins. § 6.11(3)(a)(1). Prompt is defined as 10 consecutive days from receipt of a communication concerning a claim. See Wis. Admin. Code Ins. § 6.11(4).

Another example of unfair acts by an insurer is the failure to promptly provide necessary claims forms, instructions and reasonable assistance to the insureds and claimants under insurance policies. See Wis. Admin. Code Ins. § 6.11(3)(a)(3).

Prompt, Fair and Equitable Settlement of Claim

Under Wisconsin law, certain acts by the insurer if committed with such frequency as to indicate a general business practice, shall constitute unfair methods and practices in the business of insurance. See Wis. Admin. Code Ins. § 6.11(3)

An example of unfair acts by an insurer is the failure to initiate and conclude a claims investigation with all reasonable dispatch. See Wis. Admin. Code Ins. § 6.11(3)(a)(2).

Another example of unfair acts by an insurer is the failure to attempt in good faith to effectuate fair and equitable settlement of claims submitted in which liability has become reasonably clear. See Wis. Admin. Code Ins. § 6.11(3)(a)(4).
6.11 Insurance claim settlement practices.

(1) Purpose. This rule is to promote the fair and equitable treatment of policyholders, claimants and insurers by defining certain claim adjustment practices which are considered to be unfair methods and practices in the business of insurance. The rule implements and interprets applicable statutes including but not limited to ss. 601.04 (3), 601.01 (2), and 645.41 (3), Stats.

(2) Scope. This rule applies to the kinds of insurance identified in s. Ins 6.75, transacted by insurers as defined in s. 600.03 (27), Stats., and nonprofit service plans subject to ch. 613, Stats.

(3) Unfair claim settlement practices. (a) Any of the following acts, if committed by any person without just cause and performed with such frequency as to indicate general business practice, shall constitute unfair methods and practices in the business of insurance:

1. Failure to promptly acknowledge pertinent communications with respect to claims arising under insurance policies.
2. Failure to initiate and conclude a claims investigation with all reasonable dispatch.
3. Failure to promptly provide necessary claims forms, instructions and reasonable assistance to insureds and claimants under its insurance policies.
4. Failure to attempt in good faith to effectuate fair and equitable settlement of claims submitted in which liability has become reasonably clear.
5. Failure upon request of a claimant, to promptly provide a reasonable explanation of the basis in the policy contract or applicable law for denial of a claim or for the offer of a compromise settlement.
6. Knowingly misrepresenting to claimants pertinent facts or policy provisions relating to coverages involved.
7. Failure to affirm or deny coverage of claims within a reasonable time after proof of loss has been completed.
8. Failure to settle a claim under one portion of the policy coverage in order to influence a settlement under another portion of the policy coverage.
9. Except as may be otherwise provided in the policy contract, the failure to offer settlement under applicable first party coverage on the basis that responsibility for payment should be assumed by other persons or insurers.
10. Compelling insureds and claimants to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them.
11. Refusing payment of claims solely on the basis of the insured’s request to do so without making an independent evaluation of the insured’s liability based upon all available information.

12. Failure, where appropriate, to make use of arbitration procedures authorized or permitted under any insurance policy.

13. Adopting or making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

(b) Any of the following acts committed by any person shall constitute unfair methods and practices in the business of insurance:

1. Knowingly misrepresenting to claimants pertinent facts or policy provisions relating to coverages involved.

2. Failure to make provision for adequate claims handling personnel, systems and procedures to effectively service claims in this state incurred under insurance coverage issued or delivered in this state.

3. Failure to adopt reasonable standards for investigation of claims arising under its insurance policies.

4. Violating the requirements established in s. 632.85, Stats.

(4) Prompt defined. Except where a different period is specified by statute or rule and except for good cause shown, the terms “prompt” and “promptly” as used in this rule shall mean responsive action within 10 consecutive days from receipt of a communication concerning a claim.

(5) Penalty. The commission of any of the acts listed in sub. (3) (a) or (b) 2. or 3. shall subject the person to revocation of license to transact insurance in this state. Violations of this rule or any order issued thereunder shall subject the person violating the same to s. 601.64, Stats.
Acknowledgment of Claim

Under Wyoming law, certain practices committed by an insurer with respect to claims, if performed with such frequency as to indicate a general business practice, are defined as unfair and deceptive practices and are prohibited. See Wyo. Stat. § 26-13-124(a).

One such practice is failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under policies. See Wyo. Stat. § 26-13-124(a)(ii).

Prompt, Fair and Equitable Settlement of Claim

Under Wyoming law, certain practices committed by an insurer with respect to claims, if performed with such frequency as to indicate a general business practice, are defined as unfair and deceptive practices and are prohibited. See Wyo. Stat. § 26-13-124(a).

One such practice is failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under policies. See Wyo. Stat. § 26-13-124(a)(iii).

Another such practice is failing to affirm or deny coverage of claims within a reasonable time after proof of loss requirements under the policy have been completed. See Wyo. Stat. § 26-13-124(a)(v).

Another such practice is not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear. See Wyo. Stat. § 26-13-124(a)(vi).
§ 26-13-124 Unfair claims settlement practices.

(a) A person is considered to be engaging in an unfair method of competition and unfair and deceptive act or practice in the business of insurance if that person commits or performs with such frequency as to indicate a general business practice any of the following unfair claims settlement practices:

(i) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

(ii) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

(iii) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

(iv) Refusing to pay claims without conducting a reasonable investigation based upon all available information;

(v) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(vi) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;

(vii) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds;

(viii) Attempting to settle a claim for less than the amount to which a reasonable person would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application;

(ix) Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of, the insured;

(x) Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which the payments are being made;

(xi) Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;
(xii) Delaying the investigation or payment of claims by requiring an insured, claimant or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(xiii) Failing to promptly settle claims, where liability has become reasonably clear, under one (1) portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage; or

(xiv) 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.