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SUMMARY OF CLAIMS HANDLING STATUTES NORTHWEST JURISDICTIONS

COZEN O'CONNOR
1201 THIRD AVENUE, SUITE 5200
SEATTLE, WA 98101
(206) 340-1000
FAX: (206) 621-8783

WWW.COZEN.COM

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**SUMMARY OF CLAIMS HANDLING STATUTES
NORTHWEST JURISDICTIONS**

STATE	TIME PERIOD IN WHICH INSURER MUST ACKNOWLEDGE CLAIM	TIME PERIOD IN WHICH INSURER MUST REPORT INVESTIGATION OF CLAIM
ALASKA	10 working days	15 working days after receipt of proof of loss and every 45 working days thereafter
CALIFORNIA	15 calendar days	40 calendar days after receipt of proof of loss and every 30 calendar days thereafter
COLORADO	Promptly	Reasonable time
IDAHO	Promptly	Reasonable time
MONTANA	Promptly	Reasonable time
OREGON	30 calendar days	30 calendar days after receipt of proof of loss and every 45 days thereafter
WASHINGTON	10 working days	15 working days after receipt of proof of loss and every 30 days thereafter

* This outline is an overview and does not purport to be comprehensive. Users are advised to consult appropriate state statutes, regulations and common law developments in this continually evolving area of the law.

ALASKA

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).

ALASKA ADMINISTRATIVE CODE
TITLE 3. COMMERCE, COMMUNITY, AND ECONOMIC DEVELOPMENT
PART 2. DIVISION OF INSURANCE
CHAPTER 26. TRADE PRACTICES
ARTICLE 1. UNFAIR CLAIMS SETTLEMENT ACTS OR PRACTICES
(Current through Register 181, April 2007)

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.

3 AAC 26.060. **Disclosure and representation of coverage provisions.**

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.

3 AAC 26.070. **Standards for prompt, fair, and equitable settlements.**

(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.

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).

BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS
TITLE 10. INVESTMENT
CHAPTER 5. INSURANCE COMMISSIONER
SUBCHAPTER 7.5. UNFAIR OR DECEPTIVE ACTS OR PRACTICES IN THE BUSINESS OF
INSURANCE
ARTICLE 1. FAIR CLAIMS SETTLEMENT PRACTICES REGULATIONS
(This database is current through 05/25/07, Register 2007, No. 21)

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 by 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.

s 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).

COLORADO REVISED STATUTES
TITLE 10. INSURANCE
ARTICLE 3. REGULATION OF INSURANCE COMPANIES
PART 11. UNFAIR COMPETITION – DECEPTIVE PRACTICES
(Current through laws effective April 26, 2007)

§ 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 factually disclosing relevant features and benefits for which the policy is issued and by which an informed decision can be 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)(I) 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;

(V) Repealed by Laws 1980, S.B.114, § 2, eff. April 10, 1980.

(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.

(3) Repealed by Laws 1981, H.B.1256, § 5, eff. June 4, 1981.

(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)

IDAHO

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).

IDAHO CODE
TITLE 41. INSURANCE
CHAPTER 13. TRADE PRACTICES AND FRAUDS
(Current through all 2007 laws of the First Regular Session)

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.

MONTANA

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).

MONTANA CODE ANNOTATED
TITLE 33. INSURANCE AND INSURANCE COMPANIES
CHAPTER 18. UNFAIR TRADE PRACTICES
PART 2. INSURER'S RELATIONS WITH INSURED AND CLAIMANT

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.

OREGON

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).

OREGON ADMINISTRATIVE RULES COMPILATION
CHAPTER 836. DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, INSURANCE
DIVISION
DIVISION 80. TRADE PRACTICES
TRADE PRACTICES (ORS CHAPTER 746) GENERAL (ORS 746.005 TO 746.270)
(Current with amendments included in the Oregon Bulletin,
Volume 46, Number 5, dated May 1, 2007)

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 notification and every 45 days thereafter while the investigation remains incomplete, the insurer shall notify the claimant in writing of the reason additional time is needed for investigation.

- (5) 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.
- (6) 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.
- (7) 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.

WASHINGTON

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.

WASHINGTON ADMINISTRATIVE CODE

TITLE 284. INSURANCE COMMISSIONER, OFFICE OF THE

CHAPTER 30. TRADE PRACTICES

UNFAIR CLAIMS SETTLEMENT PRACTICES

(Current through Jan. 3, 2007)

WAC 284-30-320. Definitions.

When used in this regulation:

- (1) "Agent" means any individual, corporation, association, partnership or other legal entity authorized to represent an insurer with respect to a claim;
- (2) "Claimant" means either a first party claimant, a third party claimant, or both and includes such claimant's designated legal representative and includes a member of the claimant's immediate family designated by the claimant;
- (3) "First party claimant" means an individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by such policy or contract;
- (4) "Insurance policy" or "insurance contract" mean any contract of insurance, indemnity, suretyship, or annuity issued, proposed for issuance, or intended for issuance by any insurer;
- (5) "Insurer" means any individual, corporation, association, partnership, reciprocal exchange, interinsurer, Lloyds insurer, fraternal mutual insurer, fraternal mutual life insurer, and any other legal entity engaged in the business of insurance, authorized or licensed to issue or who issues any insurance policy or insurance contract in this state. "Insurer" does not include health care service contractors, as defined in RCW 48.44.010, and health maintenance organizations, as defined in RCW 48.46.020;
- (6) "Investigation" means all activities of an insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy or insurance contract;
- (7) "Notification of claim" means any notification, whether in writing or other means acceptable under the terms of an insurance policy or insurance contract, to an insurer or its agent, by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim; and
- (8) "Third party claimant" means any individual, corporation, association, partnership or other legal entity asserting a claim against any individual, corporation, association, partnership or other legal entity insured under an insurance policy or insurance contract of an insurer.

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.