STATE OF OKLAHOMA

2nd Session of the 44th Legislature (1994)

COMMITTEE SUBSTITUTE
FOR ENGROSSED
SENATE BILL NO. 1033 By: Stipe of the Senate

and

Settle of the House

COMMITTEE SUBSTITUTE

An Act relating to insurance; amending 36 O.S. 1991, Sections 1221, 1223, as amended by Section 3, Chapter 74, O.S.L. 1992, 1224, 1225, 1226, 1227, as amended by Section 4, Chapter 74, O.S.L. 1992, 1252, 1253, 1254, as amended by Section 1, Chapter 24, O.S.L. 1993, 1255, 1256, as amended by Section 1, Chapter 248, O.S.L. 1993, 1257, as amended by Section 1, Chapter 225, O.S.L. 1993, 1258, 1259 and 1260 (36 O.S. Supp. 1993, Sections 1223, 1227, 1254, 1256 and 1257), which relate to unfair insurance claim settlement practices and resolution of insurance claims; merging the Claims Resolution Act into the Unfair Claim Settlement Practices Act and making act part of the Oklahoma Insurance Code; renaming act; modifying definitions; stating conditions under which certain acts are unfair claim settlement practices; requiring response to communication from claimant within certain time period; modifying and adding acts which constitute unfair claim settlement practices; deleting duplicate language; clarifying language; modifying statutory references; conforming language; requiring certain payment be made in certain manner; providing for judicial review for certain orders; requiring Insurance Commissioner formulate and promulgate rules to implement and administer act; repealing 36 O.S. 1991, Sections 1222, as amended by Section 2, Chapter 74, O.S.L. 1992, 1228 and 1251 (36 O.S. Supp. 1993, Section 1222), which relate to unfair claim settlement practices, promulgation of rules and short title; providing for codification; providing for recodification; and providing an effective date.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. AMENDATORY 36 O.S. 1991, Section 1221, is amended to read as follows:

Section 1221. Sections ~~5~~ 1 through ~~12~~ 16 of this act shall constitute a part of the Oklahoma Insurance Code and shall be

known and may be cited as the "Unfair ~~Claim~~ Claims Settlement Practices Act".

SECTION 2. AMENDATORY 36 O.S. 1991, Section 1252, is amended to read as follows:

Section 1252. As used in the ~~Claims Resolution~~ Unfair Claims Settlement Practices Act:

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, ~~including a subscriber under any plan providing health services,~~ a third party claimant, or both, and includes such claimant's designated legal representatives and includes a member of the claimant's immediate family designated by the claimant;

3. "Commissioner" means the ~~State~~ Insurance Commissioner;

4. "First party claimant" means an individual, corporation, association, partnership, or other legal entity, including a subscriber under any plan providing health services, asserting a right to payment pursuant to an insurance policy or insurance contract for an occurrence of contingency or loss covered by such policy or contract;

5. "Insurance policy or insurance contract" means any contract of insurance, certificate, indemnity, medical or hospital service, suretyship, or annuity issued, proposed for issuance, or intended for issuance by any entity subject to this Code;

6. "Insurer" means a person licensed by the Commissioner to issue or who issues any insurance policy or insurance contract in this state;

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

8. "Notification of claim" means any notification, whether in writing or other means acceptable under the terms of 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

9. "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.

SECTION 3. AMENDATORY 36 O.S. 1991, Section 1227, as amended by Section 4, Chapter 74, O.S.L. 1992 (36 O.S. Supp. 1993, Section 1227), is amended to read as follows:

Section 1227. A. The provisions of the Unfair ~~Claim~~ Claims Settlement Practices Act shall apply to all claims arising under an insurance ~~policies~~ policy or insurance ~~contracts~~ contract issued by any insurer.

B. It is an unfair claim settlement practice for any insurer to commit any act set out in Section 5 of this act, or to commit a violation of any other provision of the Unfair Claims Settlement Practices Act, if:

1. It is committed flagrantly and in conscious disregard of this act or any rules promulgated hereunder; or

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

SECTION 4. AMENDATORY 36 O.S. 1991, Section 1253, is amended to read as follows:

Section 1253. A. An insurer's claim files shall be subject to examination by the Insurance Commissioner or by his duly appointed designees. Such files shall contain all notes and work papers pertaining to a claim in such detail that pertinent events and the dates of such events can be reconstructed.

B. Every insurer, upon receipt of any inquiry from the Commissioner concerning a claim or a problem involving premium monies shall, within fifteen (15) business days after receipt of such inquiry, furnish the Commissioner with an adequate response to the inquiry.

C. Every insurer, upon receipt of any pertinent written communication from a claimant which reasonably suggests that a

response is expected, shall, within twenty (20) business days after receipt thereof, furnish the claimant with an adequate response to the communication.

SECTION 5. AMENDATORY 36 O.S. 1991, Section 1254, as amended by Section 1, Chapter 24, O.S.L. 1993 (36 O.S. Supp. 1993, Section 1254), is amended to read as follows:

Section 1254. Any of the following acts by an insurer, if committed in violation of Section 3 of this act, constitutes an unfair claim settlement practice:

1. ~~No insurer shall fail~~ Failing to fully disclose to first party claimants, benefits, coverages, or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim~~.~~;

2. ~~No agent shall conceal from first party claimants, benefits, coverages, or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim.~~ Knowingly misrepresenting to claimants pertinent facts or policy provisions relating to coverages at issue;

3. Failing to adopt and implement reasonable standards for prompt investigations of claims arising under its insurance policies or insurance contracts;

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

~~3. No insurer shall deny~~ 5. Denying a claim for failure to exhibit the property without proof of demand and unfounded refusal by a claimant to do so~~.~~;

~~4. No insurer, except~~ 6. Except where there is a time limit specified in the policy, ~~shall make~~ making statements, written or otherwise, ~~requiring~~ which require a claimant to give written notice of loss or proof of loss within a specified time limit and which seek to relieve the company of its obligations if such a time limit is not complied with unless the failure to comply with such time limit prejudices an insurer's rights~~.~~;

~~5. No insurer shall request~~ 7. Requesting a claimant to sign a release that extends beyond the subject matter that gave rise to the claim payment~~.~~;

~~6. No insurer shall issue~~ 8. Issuing checks or drafts in partial settlement of a loss or claim under a specified coverage which contain language which releases an insurer or its insured from its total liability~~.~~;

~~7. No insurer transacting health insurance in this state, or administrator, as defined in Section 1442 of this title, shall deny~~ 9. Denying payment to a claimant on the grounds that services, procedures or supplies provided by a treating physician or a hospital were not medically necessary unless ~~said~~ the health insurer or administrator, as defined in Section 1442 of this title, first obtains an opinion from a licensed health care provider, and preceded by a medical examination or claim review, to the effect that the services, procedures or supplies for which payment is being denied were not medically necessary. Upon written request of a claimant, treating physician or hospital, such opinion shall be set forth in a written report, prepared and signed by the reviewing health care provider. The report shall detail which specific services, procedures or supplies were not medically necessary, in the opinion of the reviewing health care provider, and an explanation of that conclusion. A copy of each report of a reviewing health care provider shall be mailed by the health insurer, or administrator, postage prepaid, to the claimant, treating physician or hospital requesting same within fifteen (15) days after receipt of such written request. As used in this subsection, "physician" means a person holding a valid license to practice medicine and surgery, osteopathy, podiatry, chiropractic or optometry, pursuant to the state licensing provisions of Title 59 of the Oklahoma Statutes~~.~~;

~~8. No insurer transacting health insurance in this state, or administrator, as defined in Section 1442 of this title, shall compensate~~ 10. Compensating a reviewing health care provider on the basis of a percentage of the amount by which a claim is reduced for payment~~.~~;

~~9. All payment or satisfaction of a claim for a motor vehicle which has been transferred by title to the insurer shall be paid by check or draft, payable on demand.~~

11. Compelling policyholders to institute suits to recover amounts due under its insurance policies or insurance contracts by offering substantially less than the amounts ultimately recovered in suits brought by them, when such policyholders have made claims for amounts reasonably similar to the amounts ultimately recovered; or

12. Failing to maintain a complete record of all complaints which it has received during the preceding three (3) years or since the date of its last examination by the Commissioner, whichever time is shorter. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint. For the purposes of this paragraph, "complaint" means any written communication primarily expressing a grievance.

SECTION 6. AMENDATORY 36 O.S. 1991, Section 1255, is amended to read as follows:

Section 1255. A. Every property and casualty insurer, within twenty (20) business days after receiving notification of a claim, shall acknowledge the receipt of such notification 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 property and casualty insurer, and dated. Notification given to an agent of a property and casualty insurer shall be notification to the insurer.

~~B. Every property and casualty insurer, upon receipt of any inquiry from the Commissioner concerning a claim or a problem involving premium monies shall, within fifteen (15) business days after receipt of such inquiry, furnish the Commissioner with an adequate response to the inquiry.~~

~~C. An appropriate reply shall be made within twenty (20) business days after receipt for all other pertinent written~~

~~communications from a claimant which reasonably suggests that a response is expected.~~

~~D.~~ B. Every property and casualty insurer, upon receiving notification of a claim, promptly shall provide necessary claim forms, instruction, and reasonable assistance so that first party claimants can comply with the policy conditions and the reasonable requirements of the property and casualty insurer. Compliance with this paragraph within twenty (20) business days after notification of a claim shall constitute compliance with subsection A of this section.

SECTION 7. AMENDATORY 36 O.S. 1991, Section 1256, as amended by Section 1, Chapter 248, O.S.L. 1993 (36 O.S. Supp. 1993, Section 1256), is amended to read as follows:

Section 1256. A. Within thirty (30) business days after receipt by a property and casualty 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, or if further investigation is necessary. No property and casualty insurer shall deny a claim because of a specific policy provision, condition, or exclusion unless reference to such provision, condition, or exclusion is included in the denial. A denial shall be given to any claimant in writing, and the claim file of the property and casualty insurer shall contain a copy of the denial. If there is a reasonable basis supported by specific information available for review by the Commissioner that the first party claimant has fraudulently caused or contributed to the loss, a property and casualty insurer shall be relieved from the requirements of this subsection. In the event of a weather-related catastrophe or a major natural disaster, as declared by the Governor, the Insurance Commissioner may extend the deadline imposed under this subsection an additional fifteen (15) business days.

B. If a claim is denied for reasons other than those described in subsection A of this section, and is made by any other means than writing, an appropriate notation shall be made in

the claim file of the property and casualty insurer until such time as a written confirmation can be made.

C. Every property and casualty insurer shall complete investigation of a claim within forty-five (45) business days after notification of proof of loss unless such investigation cannot reasonably be completed within such time. If such investigation cannot be completed, or if a property and casualty insurer needs more time to determine whether a claim should be accepted or denied, it shall so notify the claimant within forty-five (45) business days after receipt of the proofs of loss, giving reasons why more time is needed. If the investigation remains incomplete, a property and casualty insurer shall, within forty-five (45) business days from the date of the initial notification, send to such claimant a letter setting forth the reasons additional time is needed for investigation. Except for an investigation of possible fraud or arson which is supported by specific information giving a reasonable basis for the investigation, the time for investigation shall not exceed ninety (90) business days after receipt of proof of loss. Provided, in the event of a weather-related catastrophe or a major natural disaster, as declared by the Governor, the Insurance Commissioner may extend this deadline for investigation an additional fifteen (15) business days.

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

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

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

G. If a lawsuit on the claim is initiated, the time limits provided for in this section shall not apply.

SECTION 8. AMENDATORY 36 O.S. 1991, Section 1257, as amended by Section 1, Chapter 225, O.S.L. 1993 (36 O.S. Supp. 1993, Section 1257), is amended to read as follows:

Section 1257. A. If an insurance policy or insurance contract provides for the adjustment and settlement of first party motor vehicle total losses, on the basis of actual cash value or replacement with another of like kind and quality, one of the following methods shall apply:

1. An insurer may elect to offer a replacement motor vehicle which is a specific comparable motor vehicle available to the insured, with all applicable taxes, license fees, and other fees incident to the transfer of evidence of ownership of the motor vehicle paid, at no cost to the insured other than any deductible provided in the policy. The offer and any rejection thereof shall be documented in the claim file; or

2. An insured may elect a cash settlement based upon the actual cost, less any deductible provided in the policy, to purchase a comparable motor vehicle, including all applicable taxes, license fees and other fees incident to a transfer of evidence of ownership, or a comparable motor vehicle. Such cost may be determined by:

a. the cost of a comparable motor vehicle in the local market area when a comparable motor vehicle is available in the local market area, ~~or~~

b. one of two or more quotations obtained by an insurer from two or more qualified dealers located within the local market area when a comparable motor vehicle is not available in the local market area, or

c. the cost of a comparable motor vehicle as quoted in the latest edition of the National Automobile Dealers Association Official Used Car Guide.

B. If a first party motor vehicle total loss is settled on a basis which deviates from the methods described in subsection A of this section, the deviation shall be supported by documentation giving particulars of the condition of the motor vehicle. Any deductions from such cost, including, but not limited to, deduction for salvage, shall be measurable, discernible, itemized and specified as to dollar amount and shall be appropriate in amount. The basis for such settlement shall be fully explained to a first party claimant.

C. If liability for motor vehicle damages is reasonably clear, insurers shall not recommend that third party claimants make claims pursuant to the third party claimants' own policies solely to avoid paying claims pursuant to such insurer's insurance policy or insurance contract.

D. Insurers shall not require a claimant to travel unreasonably either to inspect a replacement motor vehicle, obtain a repair estimate or have the motor vehicle repaired at a specific repair shop.

E. Insurers shall, upon the request of a claimant, include the deductible of a first party claimant, if any, in subrogation demands. Subrogation recoveries shall be shared on a proportionate basis with a first party claimant, unless the deductible amount has been otherwise recovered. No deduction for expenses shall be made from a deductible recovery unless an outside attorney is retained to collect such recovery. The deduction shall then be made for only a pro rata share of the allocated loss adjustment expense.

F. If an insurer prepares an estimate of the cost of automobile repairs, such estimate shall be in an amount for which it reasonably may be expected that the damage can be repaired satisfactorily. An insurer shall give a copy of an estimate to a claimant and may furnish to the claimant the names of one or more conveniently located repair shops, if requested by the claimant.

G. If an amount claimed is reduced because of betterment or depreciation, all information for such reduction shall be contained in the claim file. Such deductions shall be itemized and specified as to dollar amount and shall be appropriate for the amount of deductions.

H. An insurer or its representative shall not require a claimant to obtain motor vehicle repairs at a specific repair facility. An insurer or its representative shall not require a claimant to obtain motor vehicle glass repair or replacement at a specific motor vehicle glass repair or replacement facility. An insurer shall fully and promptly pay for the cost of the motor vehicle repair services or products, less any applicable deductible amount payable according to the terms of the policy. The claimant shall be furnished an itemized priced statement of repairs by the repair facility at the time of acceptance of the repaired motor vehicle. Unless a cash settlement is made, if a claimant selects a motor vehicle repair or motor vehicle glass repair or replacement facility, the insurer shall provide payment to the facility based on a competitive price, as established by that insurer through market surveys or by the insured through competitive bids at the insured's option, to determine a fair and reasonable market price for similar services. Reasonable deviation from this market price is allowed based on the facts in each case.

I. An insurer shall not use as a basis for cash settlement with a first party claimant an amount which is less than the amount which an insurer would pay if repairs were made, other than in total loss situations, unless such amount is agreed to by the insured.

J. An insurer shall not force a claimant to execute a full settlement release in order to settle a property damage claim involving a personal injury.

K. <u>All payment or satisfaction of a claim for a motor vehicle which has been transferred by title to the insurer shall be paid by check or draft, payable on demand.</u>

L. As used in this section, "total loss" means that the vehicle repair costs plus the salvage value of the vehicle meets or exceeds the actual cash value of the motor vehicle prior to the loss, as provided in used automobile dealer guidebooks.

SECTION 9. AMENDATORY 36 O.S. 1991, Section 1223, as amended by Section 3, Chapter 74, O.S.L. 1992 (36 O.S. Supp. 1993, Section 1223), is amended to read as follows:

Section 1223. A. If the Insurance Commissioner determines, based on ~~his~~ an investigation of complaints of unfair claim settlement practices, that an insurer has engaged in unfair claim settlement practices with such frequency as to indicate a general business practice and that the insurer should be subjected to closer supervision with respect to such practices, the ~~Insurance~~ Commissioner may require the insurer to file a report at such periodic intervals as the ~~Insurance~~ Commissioner deems necessary. The ~~Insurance~~ Commissioner shall also devise a statistical plan for such periodic reports, which shall contain but not be limited to the following information:

1. The total number of written claims filed, including the original amount filed for by the insured and the classification by line of insurance of each individual written claim, for the past twelve-month period or from the date of the insurer's last periodic report, whichever time is shorter;

2. The total number of written claims denied, for the past twelve-month period or from the date of the insurer's last periodic report, whichever time is shorter;

3. The total number of written claims settled, including the original amount filed for by the insured, the settled amount, and the classification of line of insurance of each individual settled claim, for the past twelve-month period or from the date of the insurer's last periodic report, whichever time is shorter;

4. The total number of written claims for which lawsuits were instituted against the insurer, including the original amount of the claim filed for by the insured, the amount of final adjudication, the reason for the lawsuit and the classification by line of insurance of each individual written claim, for the past

twelve-month period or from the date of the insurer's last periodic report, whichever time is shorter; and

5. All information required by paragraph ~~6~~ 12 of Section ~~1222~~ 5 of this ~~title~~ act.

B. For the purposes of this section, "written claims" means those claims reduced to writing and filed by a resident of this state with an insurer.

SECTION 10. AMENDATORY 36 O.S. 1991, Section 1224, is amended to read as follows:

Section 1224. A. The Insurance Commissioner may hire additional employees and examiners as needed for the enforcement of the provisions of the Unfair ~~Claim~~ Claims Settlement Practices Act.

B. The ~~Insurance~~ Commissioner shall compile the information received from an insurer pursuant to Section ~~7~~ 9 of this act in such a manner as to enable him to compare it to a minimum standard of performance which shall be promulgated by the ~~Insurance~~ Commissioner. If the ~~Insurance~~ Commissioner, after such comparison is made, finds that the insurer falls below the minimum standard of performance, he shall cause an investigation to be made of said insurer as to the reason, if any, for the substandard performance.

C. The ~~Insurance~~ Commissioner shall also provide for the receiving and processing of individual complaints alleging violations of the Unfair ~~Claim~~ Claims Settlement Practices Act by both insurers who are required to make periodic reports and those who are not required to make such reports. If the ~~Insurance~~ Commissioner in his complaint experience determines that the number and type of complaints against an insurer do not meet the minimum standard of performance or are out of proportion to those against other insurers writing similar lines of insurance, the ~~Insurance~~ Commissioner shall cause an investigation to be made of the insurer.

SECTION 11. AMENDATORY 36 O.S. 1991, Section 1225, is amended to read as follows:

Section 1225. Upon the receipt of the results of an investigation instituted pursuant to the provisions of Section ~~8~~

10 of this act, the Insurance Commissioner shall review the results and shall determine whether, by the standards set out in ~~Section 6~~ Sections 3 and 5 of this act, further action is required. If the Insurance Commissioner deems further action necessary, the Commissioner shall issue and serve upon the insurer a statement of the charges and a notice of hearing thereon to be held at a time and place fixed in the notice, which shall not be less than thirty (30) days ~~prior to~~ after the date of the service thereof. ~~Such hearing shall be conducted in accordance with Section 1206 of this title, except as said section may be inconsistent with the Unfair Claim Settlement Practices Act.~~ No insurer shall be deemed in violation of the Unfair ~~Claim~~ Claims Settlement Practices Act solely by reason of the numbers and types of such complaints or claims.

SECTION 12. AMENDATORY 36 O.S. 1991, Section 1259, is amended to read as follows:

Section 1259. All hearings held pursuant to the ~~Claims Resolution~~ Unfair Claims Settlement Practices Act shall be governed by Article II of the ~~Oklahoma~~ Administrative Procedures Act, ~~Sections 301 through 326~~ Section 308a et seq. of Title 75 of the Oklahoma Statutes.

SECTION 13. AMENDATORY 36 O.S. 1991, Section 1226, is amended to read as follows:

Section 1226. A. The Insurance Commissioner, upon finding an insurer in violation of ~~the provisions~~ any provision of the Unfair ~~Claim~~ Claims Settlement Practices Act, shall issue a cease and desist order to said insurer directing it to stop such unlawful practices. If the insurer refuses or fails to comply with said order, the ~~Insurance~~ Commissioner shall have the authority to revoke or suspend the insurer's certificate of authority. The ~~Insurance~~ Commissioner shall also have the authority to limit, regulate, and control the insurer's line of business, the insurer's writing of policy forms or other particular forms, and the insurer's volume of its line of business or its writing of policy forms or other particular forms. The ~~Insurance~~ Commissioner shall use the above authority to the extent ~~he deems~~

deemed necessary to obtain the insurer's compliance ~~to his~~ with the order. The Attorney General shall offer his assistance if requested by the ~~Insurance~~ Commissioner to enforce the ~~Insurance~~ Commissioner's orders.

B. ~~Any insurer affected by a ruling or order of the Insurance Commissioner pursuant to the provisions of the Unfair Claim Settlement Practices Act may seek judicial review of same by filing suit in the district court of Oklahoma County within twenty (20) days from the date of the order of the Insurance Commissioner. Such judicial review shall be pursuant to the Administrative Procedures Act, Section 301 et seq. of Title 75 of the Oklahoma Statutes.~~ Reasonable attorneys fees shall be awarded the ~~Insurance~~ Commissioner if judicial action is necessary for the enforcement of ~~his~~ the orders.

SECTION 14. AMENDATORY 36 O.S. 1991, Section 1258, is amended to read as follows:

Section 1258. For any violation of the ~~Claims Resolution~~ Unfair Claims Settlement Practices Act, the Insurance Commissioner may, after ~~a~~ notice and hearing, subject ~~a person~~ an insurer to a civil fine of not less than One Hundred Dollars ($100.00) nor more than One Thousand Dollars ($1,000.00) for each occurrence. Such fine may be enforced in the same manner in which civil judgments may be enforced. Such fines shall be placed in the Insurance Commissioner's Revolving Fund.

SECTION 15. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1250.15 of Title 36, unless there is created a duplication in numbering, reads as follows:

Any insurer affected by an order of the Insurance Commissioner issued pursuant to the Unfair Claims Settlement Practices Act may seek judicial review of such order by filing a petition in the District Court of Oklahoma County within thirty (30) days after the insurer is notified of the order. Such judicial review shall be governed by Article II of the Administrative Procedures Act, Section 308a et seq. of Title 75 of the Oklahoma Statutes.

SECTION 16. AMENDATORY 36 O.S. 1991, Section 1260, is amended to read as follows:

Section 1260. The Insurance Commissioner shall formulate, adopt and promulgate rules ~~and regulations~~ for the implementation and administration of the ~~provisions of the Claims Resolution~~ Unfair Claims Settlement Practices Act.

SECTION 17. RECODIFICATION 36 O.S. 1991, Sections 1221, as amended by Section 1 of this act, 1252, as amended by Section 2 of this act, 1227, as last amended by Section 3 of this act, 1253, as amended by Section 4 of this act, 1254, as last amended by Section 5 of this act, 1255, as amended by Section 6 of this act, 1256, as last amended by Section 7 of this act, 1257, as last amended by Section 8 of this act, 1223, as last amended by Section 9 of this act, 1224, as amended by Section 10 of this act, 1225, as amended by Section 11 of this act, 1259, as amended by Section 12 of this act, 1226, as amended by Section 13 of this act, and 1258, as amended by Section 14 of this act, shall be recodified as Sections 1250.1, 1250.2, 1250.3, 1250.4, 1250.5, 1250.6, 1250.7, 1250.8, 1250.9, 1250.10, 1250.11, 1250.12, 1250.13 and 1250.14 of Title 36 of the Oklahoma Statutes respectively; and 36 O.S. 1991, Section 1260, as amended by Section 16 of this act, shall be recodified as Section 1250.16 of Title 36 of the Oklahoma Statutes unless there is created a duplication in numbering.

SECTION 18. REPEALER 36 O.S. 1991, Sections 1222, as amended by Section 2, Chapter 74, O.S.L. 1992, 1228 and 1251 (36 O.S. Supp. 1993, Section 1222), are hereby repealed.

SECTION 19. This act shall become effective September 1, 1994.

44-2-9418 SD