

ENROLLED SENATE
BILL NO. 729

By: Smith of the Senate

and

Sullivan (John) of the
House

An Act relating to insurance and motor vehicles; amending 36 O.S. 1991, Sections 110, as last amended by Section 1, Chapter 118, O.S.L. 1994, Section 2, Chapter 250, O.S.L. 1995, Section 4, Chapter 250, O.S.L. 1995, Section 6, Chapter 250, O.S.L. 1995, Section 7, Chapter 250, O.S.L. 1995, Section 8, Chapter 250, O.S.L. 1995 and Section 12, Chapter 250, O.S.L. 1995 (36 O.S. Supp. 1995, Sections 110, 6532, 6534, 6536, 6537, 6538 and 6542), which relate to entities to which Insurance Code does not apply and the Health Insurance High Risk Pool Act; deleting exemption for title and surety insurance business of certain trust companies; modifying certain definition; modifying residence requirements; modifying eligibility requirements; updating statutory references; changing powers of the Board of Directors of the Health Insurance High Risk Pool; authorizing the Board to terminate services of the administering insurer under certain circumstances; deleting prohibitions relating to policies issued to persons eligible for Medicare; providing for recognizing certain claims; amending 47 O.S. 1991, Section 583, as last amended by Section 10, Chapter 373, O.S.L. 1992 (47 O.S. Supp. 1995, Section 583), which relates to licensure of used motor vehicle dealers and manufactured home dealers; updating language; repealing Sections 2, 4, 6, 7, 8 and 12, Chapter 250, O.S.L. 1995 (36 O.S. Supp. 1995, Sections 6532, 6534, 6536, 6537, 6538 and 6542), as amended by Sections 19, 20, 21, 22, 23 and 24 of Enrolled House Bill No. 2553 of the 2nd Session of the 45th Oklahoma Legislature, which relate to the Health Insurance High Risk Pool Act; and declaring an emergency.

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

SECTION 1. AMENDATORY 36 O.S. 1991, Section 110, as last amended by Section 1, Chapter 118, O.S.L. 1994 (36 O.S. Supp. 1995, Section 110), is amended to read as follows:

Section 110. No provision of the Oklahoma Insurance Code, Section 101 et seq. of this title, shall apply to:

1. Nonprofit hospital service and medical indemnity corporations, except as stated in Sections 601 et seq. and 2601 et seq. of this title; or
2. Fraternal benefit societies, except as stated in Section 2701 et seq. of this title; or
3. Farmers' mutual fire insurance associations, except as stated in Section 2801 et seq. of this title; or
4. Mutual benefit associations, except as stated in Section 2401 et seq. of this title; or
5. Domestic burial associations; or
6. Any domestic association organized subject to the supervision or by the authority of any incorporated Grange Order of Patrons of Husbandry, when the association is formed exclusively for the mutual benefit of the members of such order. Effective January 1, 1982, The Oklahoma State Union of the Farmers' Educational and Cooperative Union of America shall comply with all provisions of the Oklahoma Insurance Code; or
7. Trust companies organized pursuant to the provisions of Title 6 of the Oklahoma Statutes ~~engaged in~~ except that the title insurance and surety insurance as defined in Section 701 et seq. of this title business of such trust companies shall be subject to the Oklahoma Insurance Code; or
8. Soliciting agents of mutual insurance corporations or associations, operating only in this state, that issue no stock or other form of security, do not operate for profit, and have none of their funds inure to the benefit of individuals except in the form of less expensive insurance and necessary expenses of operation, if provisions are made in the bylaws of the insurer for the election of any soliciting agents by a majority of the policyholders in the area where the soliciting agent solicits insurance; or
9. The Mutual Aid Association of the Church of the Brethren or the Mutual Aid Association of the Mennonite and Brethren in Christ; or
10. Incorporated or unincorporated banking associations having been in existence for over fifteen (15) years and consisting of more than seventy-five (75) member banks within this state for issuance of blanket fidelity bonds for banks within this state for each bank's own use, or any nonprofit trust sponsored by such associations' member banks providing employee benefits such as life, health, accident, disability, pension and retirement benefits for banks, bank holding companies and subsidiaries thereof, the associations' employees and associate members, if the association uses standard forms and provides information to the Bank Commissioner adequate for a determination of actuarial soundness; or
11. A religious publication, or subscribers of the publication, when the publication:
 - a. is a nonprofit religious organization,
 - b. is limited to subscribers who are members of the same denomination or religion,
 - c. acts as an organizational clearinghouse for information between subscribers who have financial, physical or medical needs and subscribers with the present ability to pay subscribers with present financial or medical needs,
 - d. provides for the financial or medical needs of a subscriber through payments directly from one subscriber to another, and
 - e. suggests amounts that subscribers may voluntarily give with no assumption of risk or promise to pay either

among the subscribers or between the subscribers and the publication.

SECTION 2. AMENDATORY Section 2, Chapter 250, O.S.L. 1995 (36 O.S. Supp. 1995, Section 6532), is amended to read as follows:

Section 6532. As used in ~~Sections 1 through 14~~ of the Health Insurance High Risk Pool Act:

1. "Agent" means any person who is licensed to sell health insurance in this state;

2. "Board" means the Board of Directors of the Health Insurance High Risk Pool;

3. "Health insurance" means any individual or group hospital or medical expense-incurred policy or health care benefits plan or contract. The term does not include any policy governing short-term accidents only, a fixed-indemnity policy, a limited benefit policy, a specified accident policy, a specified disease policy, a Medicare supplement policy, a long-term care policy, ~~a limited benefit expense policy~~, medical payment or personal injury coverage in a motor vehicle policy, coverage issued as a supplement to liability insurance, a disability policy, or workers' compensation;

4. "Insurer" means any individual, corporation, association, partnership, fraternal benefit society, or any other entity engaged in the health insurance business, except insurance agents and brokers. This term shall also include not-for-profit hospital service and medical indemnity plans, health maintenance organizations, preferred provider organizations, prepaid health plans, the State and Education Employees Group Health Insurance Plan, and any reinsurer reinsuring health insurance in this state, which shall be designated as engaged in the business of insurance for the purposes of this act;

5. "Medicare" means coverage under Parts A and B of Title XVIII of the Social Security Act (Public Law 74-271, 42 U.S.C., Section 1395 et seq., as amended);

6. "Pool" means the Health Insurance High Risk Pool;

7. "Physician" means a doctor of medicine and surgery, doctor of osteopathic medicine, doctor of chiropractic, doctor of podiatric medicine, doctor of optometry, and, for purposes of oral and maxiofacial surgery only, a doctor of dentistry, each duly licensed by this state;

8. "Plan" means the comprehensive health insurance benefit plan as adopted by the Board of Directors of the Health Insurance High Risk Pool, or by rule; and

9. "Reinsurer" means any insurer as defined in Section 103 of this title from whom any person providing health insurance to Oklahoma insureds procures insurance for itself as the insurer, with respect to all or part of the health insurance risk of the person.

SECTION 3. AMENDATORY Section 4, Chapter 250, O.S.L. 1995 (36 O.S. Supp. 1995, Section 6534), is amended to read as follows:

Section 6534. A. Except as otherwise provided in this section, any ~~resident of~~ person who maintains a primary residence in this state for at least one (1) year shall be eligible for coverage under the plan of the Health Insurance High Risk Pool including:

1. The spouse of the insured; and

2. Any dependent unmarried child of the insured, from the moment of birth. Such coverage shall terminate at the end of the premium period in which the child marries, ceases to be a dependent of the insured, or attains the age of nineteen (19) years, whichever occurs first. However, if the child is a full-time student at an accredited institution of higher learning, the coverage may continue

while the child remains unmarried and a full-time student, but not beyond the premium period in which the child reaches the age of twenty-three (23) years.

B. 1. No person is eligible for coverage under the Pool plan unless such person has been rejected by at least two insurers for coverage substantially similar to the plan coverage. As used in this paragraph, rejection includes an offer of coverage with a material underwriting restriction or an offer of coverage at a rate equal to or greater than the Pool plan rate. No person is eligible for coverage under the plan if such person has, on the date of issue of coverage under the plan, equivalent coverage under another health insurance contract or policy.

2. No person who is currently receiving, or is entitled to receive, health care benefits under any federal or state program providing financial assistance or preventive and rehabilitative social services, ~~except for Medicare~~, is eligible for coverage under the plan.

3. No person who is covered under the plan and who terminates coverage is again eligible for coverage unless twelve (12) months has elapsed since the coverage was terminated. The Board may waive the twelve-month waiting period under circumstances to be determined by the Board.

4. No person on whose behalf the plan has paid out Five Hundred Thousand Dollars (\$500,000.00) in covered benefits is eligible for coverage under the plan.

5. No inmate incarcerated in any state penal institution or confined to any narcotic detention, treatment, and rehabilitation facility shall be eligible for coverage under the plan.

C. The Board may establish an annual enrollment cap if the Board determines it is necessary to limit costs to the plan.

D. The coverage of any person who ceases to meet the eligibility requirements of this section may be terminated at the end of the ~~policy period~~ month in which an individual no longer meets the eligibility requirements.

SECTION 4. AMENDATORY Section 6, Chapter 250, O.S.L. 1995 (36 O.S. Supp. 1995, Section 6536), is amended to read as follows:

Section 6536. The Board of Directors of the Health Insurance High Risk Pool shall:

1. Establish administrative and accounting procedures for the operation of the Pool;

2. Establish procedures under which applicants and participants in the plan may have grievances reviewed by an impartial body and reported to the Board;

3. Select an administering insurer in accordance with Section ~~8~~ 6538 of this ~~act~~ title;

4. Levy and collect assessments from all insurers and reinsurers to provide for claims paid under the plan and for administrative expenses incurred or estimated to be incurred during the period for which assessment is made. The level of assessments shall be established by the Board in accordance with Section ~~9~~ 6539 of this ~~act~~ title. Assessment of the insurers shall occur at the end of each calendar year and shall be due and payable within thirty (30) days of receipt of the assessment notice by the insurer;

5. In addition to assessments required pursuant to paragraph 4 of this subsection, collect an organizational assessment or assessments from all insurers and reinsurers as necessary to provide for expenses which have been incurred or are estimated to be incurred prior to the receipt of the first calendar year assessments. Organizational assessments shall be equal for all

insurers and reinsurers, but shall not exceed One Hundred Dollars (\$100.00) per insurer for all such assessments. Such assessments are due and payable within thirty (30) days of receipt of the assessment notice by the insurer;

6. Require that all policy forms issued by the Board conform to standard forms as approved by the Insurance Commissioner;

7. Develop a program to publicize the existence of the plan, the eligibility requirements of the plan, and the procedures for enrollment in the plan, and to maintain public awareness of the plan; and

8. Design and employ cost-containment measures and requirements which may include preadmission certification, home health care, hospice care, negotiated purchase of medical and pharmaceutical supplies and individual case management. The Board may employ a plan case manager or managers to supervise and manage the medical care or coordinate the supervision and management of the medical care with the administering insurer. The Board may employ other persons if the positions have been outlined in the Board's plan and approved by the Insurance Commissioner and are necessary to fulfill the duties and responsibilities of the Board.

SECTION 5. AMENDATORY Section 7, Chapter 250, O.S.L. 1995 (36 O.S. Supp. 1995, Section 6537), is amended to read as follows:

Section 6537. The ~~Board of Directors of the~~ Health Insurance High Risk Pool may:

1. Exercise powers granted to insurers under the laws of this state;

2. Sue or be sued; provided, individual members of the Board while acting in good faith within the course of their duties under the provisions of the Health Insurance High Risk Pool Act shall not be personally liable for actions taken by the Board;

3. In addition to imposing assessments under Section ~~6~~ 6536 of this ~~act~~ title, levy interim assessments against insurers and reinsurers to ensure the financial ability of the plan to cover claims, expenses and administrative expenses incurred or estimated to be incurred in the operation of the plan prior to the end of a calendar year. Any interim assessment shall be due and payable within thirty (30) days of the receipt of the assessment notice by the insurer. Interim assessments shall be credited against the insurer's and reinsurer's annual assessment; and

4. Request the Insurance Commissioner to check the reports, records, books and papers of the Insurance Department to determine the financial condition of an insurer for purposes of Section ~~10~~ 6540 of this ~~act~~ title.

SECTION 6. AMENDATORY Section 8, Chapter 250, O.S.L. 1995 (36 O.S. Supp. 1995, Section 6538), is amended to read as follows:

Section 6538. A. The Board of Directors of the Health Insurance High Risk Pool shall select an administering insurer who shall be an insurer as defined in this act, through a competitive bidding process, to administer the plan. The Board shall evaluate the bids submitted under this subsection based on criteria established by the Board, which criteria shall include, but not be limited to, the following:

1. The administering insurer's proven ability to handle large group accident and health insurance policies and claims;

2. The efficiency of the administering insurer's claims-paying procedures; and

3. An estimate of total charges for administering the plan.

B. The administering insurer shall serve for a period of two (2) years. At least one (1) year prior to the expiration of each two-year period of service by an administering insurer, the Board shall invite all reasonably interested potential administering insurers, including the current administering insurer, to submit bids to serve as the administering insurer for the succeeding two-year period. The selection of the administering insurer for the succeeding two-year period shall be made at least six (6) months prior to the end of the current two-year period. The Board may terminate the service of the administering insurer at any time if the Board determines that the administering insurer has failed to perform their duties effectively according to the contract established. In this case, the Board will accept bids from other potential administering insurers to serve the remainder of the vacated term.

C. The Board may select more than one administering insurer to perform the different functions involved in administering the plan.

D. The administering insurer shall:

1. Perform all eligibility and administrative claims-payment functions relating to the plan;

2. Pay an agent's referral fee as established by the Board to each agent who refers an applicant to the plan, if the applicant is accepted. The selling or marketing of the plan shall not be limited to the administering insurer or its agents. The referral fees shall be paid by the administering insurer from moneys received as premiums for the plan;

3. Establish a premium billing procedure for collection of premiums from persons insured under the plan;

4. Perform all necessary functions to assure timely payment of benefits to covered persons under the plan, including, but not limited to, the following:

- a. making available information relating to the proper manner of submitting a claim for benefits under the plan and distributing forms upon which submissions shall be made,
- b. evaluating the eligibility of each claim for payment under the plan, and
- c. notifying each claimant within thirty (30) days after receiving a properly completed and executed proof of loss, whether the claim is accepted, rejected, or compromised;

5. Submit regular reports to the Board regarding the operation of the plan. The frequency, content, and form of the reports shall be determined by the Board;

6. Following the close of each calendar year, determine net premiums, reinsurance premiums less administrative expenses allowance, the expense of administration pertaining to the reinsurance operations of the Pool, and the incurred losses for the year, and report this information to the Board and to the Insurance Commissioner; and

7. Pay claims expenses from the premium payments received from, or on behalf of, covered persons under the plan. If the payments by the administering insurer for claims expenses exceed the portion of premiums allocated by the Board for the payment of claims expenses, the Board shall provide through assessment the additional funds necessary for payment of claims expenses.

E. 1. The administering insurer shall be paid, as provided in the contract of the Pool, for direct and indirect expenses incurred in administering the Pool.

2. As used in this subsection, the term "direct and indirect expenses" includes the portion of the audited administrative costs, printing expenses, claims administration expenses, management expenses, building overhead expenses and other actual operating and administrative expenses of the administering insurer which are approved by the Board as allocable to the administration of the plan and included in the bid specifications.

SECTION 7. AMENDATORY Section 12, Chapter 250, O.S.L. 1995 (36 O.S. Supp. 1995, Section 6542), is amended to read as follows:

Section 6542. A. 1. The plan shall offer as one basic option an annually renewable policy with coverage as specified in this section for each eligible person, except, that if an eligible person is also eligible for Medicare coverage, the plan shall not pay or reimburse any person for expenses paid by Medicare.

2. Any person whose health insurance is involuntarily terminated for any reason other than nonpayment of premium may apply for coverage under the plan. If such coverage is applied for within sixty (60) days after the involuntary termination and if premiums are paid for the entire period of coverage, the effective date of the coverage shall be the date of termination of the previous coverage.

3. The plan shall provide that, upon the death, annulment of marriage or divorce of the individual in whose name the contract was issued, every other person covered in the contract may elect within sixty (60) days to continue coverage under a continuation or conversion policy.

4. No coverage provided to a person who is eligible for Medicare benefits shall be issued as a Medicare supplement policy.

B. ~~1.~~ The plan shall offer as a minimum major medical expense coverage to every eligible person who is not eligible for Medicare. Major medical expense coverage offered under the plan shall pay an eligible person's covered expenses, subject to the limits on the deductible and coinsurance payments authorized under subsection E of this section up to a lifetime limit of Five Hundred Thousand Dollars (\$500,000.00) per covered individual. The maximum limit under this paragraph shall not be altered by the Board of Directors of the Health Insurance High Risk Pool, and no actuarially equivalent benefit may be substituted by the Board.

~~2. The plan shall provide that any policy issued to a person eligible for Medicare shall be separately rated to reflect differences in experiences reasonably expected to occur as a result of Medicare payments.~~

C. Except for a health maintenance organization and prepaid health plan or preferred provider organization utilized by the Board or a covered person, the usual customary charges for the following services and articles, when prescribed by a physician, shall be covered expenses:

1. Hospital services;
2. Professional services for the diagnosis or treatment of injuries, illness, or conditions, other than dental, which are rendered by a physician or by others at the direction of a physician;
3. Drugs requiring a physician's prescription;
4. Services of a licensed skilled nursing facility for eligible individuals, ineligible for Medicare, for not more than one hundred eighty (180) calendar days during a policy year, if the services are the type which would qualify as reimbursable services under Medicare;

5. Services of a home health agency, if the services are of a type which would qualify as reimbursable services under Medicare;
6. Use of radium or other radioactive materials;
7. Oxygen;
8. Anesthetics;
9. Prosthesis, other than dental prosthesis;
10. Rental or purchase, as appropriate, of durable medical equipment, other than eyeglasses and hearing aids;
11. Diagnostic x-rays and laboratory tests;
12. Oral surgery for partially or completely erupted, impacted teeth and oral surgery with respect to the tissues of the mouth when not performed in connection with the extraction or repair of teeth;
13. Services of a physical therapist;
14. Transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition;
15. Processing of blood, including, but not limited to, collecting, testing, fractioning, and distributing blood; and
16. Services for the treatment of alcohol and drug abuse, but the plan shall be required to make a fifty percent (50%) co-payment and the payment of the plan shall not exceed Four Thousand Dollars (\$4,000.00).

Usual and customary charges shall not exceed the reimbursement rate for charges as set by the State and Education Employees Group Insurance Board.

- D. 1. Covered expenses shall not include the following:
 - a. any charge for treatment for cosmetic purposes, other than for repair or treatment of an injury or congenital bodily defect to restore normal bodily functions,
 - b. any charge for care which is primarily for custodial or domiciliary purposes which do not qualify as eligible services under Medicaid,
 - c. any charge for confinement in a private room to the extent that such charge is in excess of the charge by the institution for its most common semiprivate room, unless a private room is prescribed as medically necessary by a physician,
 - d. that part of any charge for services or articles rendered or provided by a physician or other health care personnel which exceeds the prevailing charge in the locality where the service is provided, or any charge for services or articles not medically necessary,
 - e. any charge for services or articles the provision of which is not within the authorized scope of practice of the institution or individual providing the service or articles,
 - f. any expense incurred prior to the effective date of the coverage under the plan for the person on whose behalf the expense was incurred,
 - g. any charge for routine physical examinations in excess of one every twenty-four (24) months,
 - h. any charge for the services of blood donors and any fee for the failure to replace the first three (3) pints of blood provided to an eligible person annually, and
 - i. any charge for personal services or supplies provided by a hospital or nursing home, or any other nonmedical or nonprescribed services or supplies.

2. The plan may provide an option for a person to have coverage for the expenses set out in paragraph 1 of this subsection or any benefits payable under any other health insurance policy or plan, commensurate with the deductible and coinsurance selected.

E. 1. The plan shall provide for a choice of annual deductibles per person covered for major medical expenses in the amounts of Five Hundred Dollars (\$500.00), One Thousand Dollars (\$1,000.00), One Thousand Five Hundred Dollars (\$1,500.00), Two Thousand Dollars (\$2,000.00), Five Thousand Dollars (\$5,000.00) and Seven Thousand Five Hundred Dollars (\$7,500.00), plus the additional benefits payable at each level of deductible; provided, if two individual members of a family satisfy the applicable deductible, no other members of the family shall be required to meet deductibles for the remainder of that calendar year.

2. The schedule of premiums and deductibles shall be established by the Board.

3. Rates for coverage issued by the Pool may not be unreasonable in relation to the benefits provided, the risk experience and the reasonable expenses of providing coverage.

4. Separate schedules of premium rates based on age may apply for individual risks.

5. Rates are subject to approval by the Insurance Commissioner.

6. Standard risk rates for coverages issued by the Pool shall be established by the Board, subject to the approval of the Insurance Commissioner, using reasonable actuarial techniques, and shall reflect anticipated experiences and expenses of such coverage for standard risks.

7. a. The rating plan established by the Board shall initially provide for rates equal to one hundred twenty-five percent (125%) of the average standard risk rates of the five largest insurers doing business in the state.

b. Any change to the initial rates shall be based on experience of the plan and shall reflect reasonably anticipated losses and expenses. The rates shall not increase more than five percent (5%) annually with a maximum rate not to exceed one hundred fifty percent (150%) of the average standard risk rates.

8. a. A Pool policy may contain provisions under which coverage is excluded during a period of twelve (12) months following the effective date of coverage with respect to a given covered person's preexisting condition, as long as:

- (1) the condition manifested itself within a period of six (6) months before the effective date of coverage, or
- (2) medical advice or treatment for the condition was recommended or received within a period of six (6) months before the effective date of coverage.

b. The Board shall waive the twelve-month period if the person had continuous coverage under another policy with respect to the given condition within a period of six (6) months before the effective date of coverage under the Pool plan.

9. a. No amounts paid or payable by Medicare or any other governmental program or any other insurance, or self-insurance maintained in lieu of otherwise statutorily required insurance, may be made or recognized as claims under such policy, or be recognized as or towards satisfaction of applicable deductibles or out-

of-pocket maximums, or to reduce the limits of benefits available, and

- b. The Board shall have a cause of action against a covered person for any benefits paid to a covered person which should not have been claimed or recognized as claims because of the provisions of this paragraph, or because otherwise not covered.

SECTION 8. AMENDATORY 47 O.S. 1991, Section 583, as last amended by Section 10, Chapter 373, O.S.L. 1992 (47 O.S. Supp. 1995, Section 583), is amended to read as follows:

Section 583. A. 1. It shall be unlawful and constitute a misdemeanor for any person, firm, association, corporation, or trust to engage in business as, or serve in the capacity of, or act as a used motor vehicle dealer, used motor vehicle ~~salesman~~ salesperson, wholesale used motor vehicle dealer, or a manufactured home dealer in this state without first obtaining a license therefor as provided in this section.

2. Any person, firm, association, corporation, or trust engaging, acting, or serving in the capacity of a used motor vehicle dealer and/or a used motor vehicle ~~salesman~~ salesperson, or a manufactured home dealer, or having more than one place where the business of a used motor vehicle dealer or a manufactured home dealer is carried on or conducted shall be required to obtain and hold a current license for each thereof in which ~~he, it or they shall engage~~ engaged. A used motor vehicle dealer's license shall authorize one person to sell without a ~~salesman's~~ salesperson's license in the event such person shall be the owner of a proprietorship, or the person designated as principal in the dealer's franchise or the managing officer or one partner if no principal person is named in the franchise. A ~~salesman's~~ salesperson's license may not be issued under a wholesale used motor vehicle dealer's license.

3. Any person, firm, association, corporation, or trust violating the provisions of this section shall, upon conviction, be fined not to exceed Five Hundred Dollars (\$500.00). A second or subsequent conviction shall be punished by a fine not to exceed One Thousand Dollars (\$1,000.00); provided that each day such unlicensed person violates this section shall constitute a separate offense, and any vehicle involved in a violation of this subsection shall be considered a separate offense.

B. 1. Applications for licenses required to be obtained under provisions of this act, Section 581 et seq. of this title, which creates the Oklahoma Used Motor Vehicle and Parts Commission shall be verified by the oath or affirmation of the applicant and shall be on forms prescribed by the Commission and furnished to the applicants, and shall contain such information as the Commission deems necessary to enable it to fully determine the qualifications and eligibility of the several applicants to receive the license or licenses applied for. The Commission shall require in the application, or otherwise, information relating to:

- a. the applicant's financial standing,
- b. the applicant's business integrity,
- c. whether the applicant has an established place of business and is engaged in the pursuit, avocation, or business for which a license, or licenses, is applied for,
- d. whether the applicant is able to properly conduct the business for which a license, or licenses, is applied for, and

e. such other pertinent information consistent with the safeguarding of the public interest and the public welfare.

2. All applications for license or licenses shall be accompanied by the appropriate fee or fees in accordance with the schedule hereinafter provided. In the event any application is denied and the license applied for is not issued, the entire license fee shall be returned to the applicant.

3. All bonds and licenses issued under the provisions of this act shall expire on December 31, following the date of issue and shall be nontransferable. All applications for renewal of dealers' licenses should be submitted by November 1 of each year, and licenses shall be issued by January 10. If applications have not been made for renewal of licenses, such licenses shall expire on December 31 and it shall be illegal for any person to represent himself or herself and act as a dealer thereafter. Tag agents shall be notified not to accept dealers' titles until such time as licenses have been issued.

4. A used motor vehicle ~~salesman's~~ salesperson's license shall permit the licensee to engage in the activities of a used motor vehicle ~~salesman~~ salesperson. ~~Salesmen~~ Salespersons shall not be allowed to sell vehicles unless applications, bonds, and fees are on file with the Commission and the motor vehicle ~~salesman's~~ salesperson's or temporary ~~salesman's~~ salesperson's license issued. A temporary ~~salesman's~~ salesperson's license, ~~salesman's~~ salesperson's renewal or reissue of ~~salesman's~~ salesperson's license shall be deemed to have been issued when the appropriate application, bond, and fee have been properly addressed and mailed to the Commission.

Dealers' payrolls and other evidence will be checked to ascertain that all ~~salesmen~~ salespersons for such dealers are licensed.

C. The schedule of license fees to be charged and received by the Commission for the licenses issued hereunder shall be as follows:

1. For each used motor vehicle dealer's license and each wholesale used motor vehicle dealer's license, Two Hundred Dollars (\$200.00). If a used motor vehicle dealer or a wholesale used motor vehicle dealer has once been licensed by the Commission in the classification for which he or she applies for a renewal of the license, the fee for each subsequent renewal shall be One Hundred Dollars (\$100.00); provided, if an applicant holds a license to conduct business as an automotive dismantler and parts recycler issued pursuant to Section 591.1 et seq. of this title, the initial fee shall be One Hundred Dollars (\$100.00) and the renewal fee shall be Seventy-five Dollars (\$75.00). If an applicant is applying simultaneously for a license under this paragraph and a license under paragraph 1 of Section 591.5 of this title, the initial application fee shall be One Hundred Fifty Dollars (\$150.00);

2. For a used motor vehicle dealer's license, for each place of business in addition to the principal place of business, Fifty Dollars (\$50.00);

3. For each used motor vehicle ~~salesman's~~ salesperson's license, Ten Dollars (\$10.00);

4. For each holder who possesses a valid new motor vehicle dealer's license from the Oklahoma Motor Vehicle Commission, One Hundred Dollars (\$100.00) shall be the initial fee for a used motor vehicle license and the fee for each subsequent renewal shall be One Hundred Dollars (\$100.00);

5. For each manufactured home dealer's license, and for each place of business in addition to the principal place of business, Two Hundred Dollars (\$200.00);

6. For each renewal of a manufactured home dealer's license, and renewal for each place of business in addition to the principal place of business, One Hundred Dollars (\$100.00).

D. 1. The license issued to each used motor vehicle dealer, each wholesale used motor vehicle dealer, and each manufactured home dealer shall specify the location of the place of business. If the business location is changed, the Commission shall be notified immediately of the change and the Commission may endorse the change of location on the license without charge. The license of each dealer shall be posted in a conspicuous place in the dealer's place or places of business.

2. Every used motor vehicle ~~salesman~~ salesperson shall have ~~his~~ the license upon his or her person when engaged in ~~his~~ business, and shall display same upon request. The name of the employer of the ~~salesman~~ salesperson shall be stated on the license and if there is a change of employer, the license holder shall immediately mail ~~his~~ the license to the Commission for its endorsement of the change thereon. There shall be no charge for endorsement of change of employer on the license or penalty for not having a license upon his or her person.

E. 1. Each applicant for a used motor vehicle dealer's license shall procure and file with the Commission a good and sufficient bond in the amount of Ten Thousand Dollars (\$10,000.00). Each applicant for a wholesale used motor vehicle dealer's license shall procure and file with the Commission a good and sufficient bond in the amount of Twenty-five Thousand Dollars (\$25,000.00). Each applicant for a manufactured home dealer's license shall procure and file with the Commission a good and sufficient bond in the amount of Thirty Thousand Dollars (\$30,000.00). The bond shall be approved as to form by the Attorney General and conditioned that the applicant shall not practice fraud, make any fraudulent representation, or violate any of the provisions of this act in the conduct of the business for which ~~he~~ the applicant is licensed. One of the purposes of the bond is to provide reimbursement for any loss or damage suffered by any person by reason of issuance of a certificate of title by a used motor vehicle dealer, a wholesale used motor vehicle dealer, or a manufactured home dealer.

2. If a motor vehicle dealer has a valid license issued by the Oklahoma Motor Vehicle Commission, then the bond as required by this subsection shall be waived.

3. Each applicant for a used motor vehicle ~~salesman's~~ salesperson's license shall procure and file with the Commission a good and sufficient bond in the amount of One Thousand Dollars (\$1,000.00). The bond shall be approved as to form by the Attorney General and conditioned that the applicant shall perform ~~his~~ duties as a used motor vehicle ~~salesman~~ salesperson without fraud or fraudulent representation and without violating any provisions of this act.

4. The bonds as required by this section shall be maintained throughout the period of licensure. Should the bond be canceled for any reason, the license shall be revoked as of the date of cancellation unless a new bond is furnished prior to such date.

F. Any used motor vehicle dealer or wholesale used motor vehicle dealer is required to furnish and keep in force a minimum of Twenty-five Thousand Dollars (\$25,000.00) of single liability insurance coverage on all vehicles offered for sale or used in any other capacity in demonstrating or utilizing the streets and

roadways in accordance with the financial responsibility laws of this state.

G. Any manufactured home dealer is required to furnish and keep in force a minimum of One Hundred Thousand Dollars (\$100,000.00) of garage liability and completed operations insurance coverage.

SECTION 9. REPEALER Sections 2, 4, 6, 7, 8 and 12, Chapter 250, O.S.L. 1995 (36 O.S. Supp. 1995, Sections 6532, 6534, 6536, 6537, 6538 and 6542), as amended by Sections 19, 20, 21, 22, 23 and 24 of Enrolled House Bill No. 2553 of the 2nd Session of the 45th Oklahoma Legislature, are hereby repealed.

SECTION 10. It being immediately necessary for the preservation of the public peace, health and safety, an emergency is hereby declared to exist, by reason whereof this act shall take effect and be in full force from and after its passage and approval.

Passed the Senate the 16th day of May, 1996.

President of the Senate

Passed the House of Representatives the 21st day of May, 1996.

Speaker of the House of Representatives