STATE OF OKLAHOMA

1st Session of the 50th Legislature (2005)

COMMITTEE SUBSTITUTE
FOR
HOUSE BILL NO. 1535 By: Peterson (Ron)

COMMITTEE SUBSTITUTE

An Act relating to insurance; amending 36 O.S. 2001, Sections 348.1, as amended by Section 4, Chapter 307, O.S.L. 2002, Section 3, Chapter 274, O.S.L. 2004, 629, as amended by Section 4, Chapter 274, O.S.L. 2004, and 903, as amended by Section 7, Chapter 519, O.S.L. 2004, 47 O.S. 2001, Section 11-801b, as renumbered by Section 35, Chapter 397, O.S.L. 2002, and 36 O.S. 2001, Sections 987, as amended by Section 19, Chapter 519, O.S.L. 2004, 991, 992, 1204, 1435.35, 1616, 1655, 3639, 4101, 6402, 6418, Section 22, Chapter 390, O.S.L. 2003, Section 6, Chapter 197, O.S.L. 2003, and Section 26, Chapter 197, O.S.L. 2003 (36 O.S. Supp. 2004, Sections 348.1, 615.2, 629, 903, 944, 987, 6821, 6906 and 6926), which relate to the Oklahoma Insurance Code; allowing Commissioner to impose fees along with Board; requiring health maintenance organizations to maintain certain information; requiring approval from Insurance Commissioner for use of third party; modifying date certain payments must be made; including every insurer in application of rate filing mandates; modifying days required for approval of rates; deleting automatic approval of certain filings; providing reference; modifying type of risk covered; modifying references to certain act; allowing filing and approval by Insurance Commissioner; modifying reference to certain act; allowing investment in certain stocks; setting investment limits; adding certain standards for certain material transactions; reducing percentage of insured's assets that can be used; modifying reference to certain act; removing policy coverage requirement; allowing for filing of rates; removing approval requirement for rates filed; requiring filing of affidavit by certain person; increasing fidelity bond or insurance maximum amount; clarifying exclusion; creating the Health Savings Account Act; stating purpose; defining terms; allowing exemption from certain mandates for certain insurance plans; amending 25 O.S. 2001, Section 307.1, as last amended by Section 14, Chapter 5, O.S.L. 2004 (25 O.S. Supp. 2004, Section 307.1), which relates to the Open Meeting Act; allowing certain board to hold meetings by teleconference; amending 85 O.S. 2001, Section 64, which relates to employer's insurance; allowing for indemnity benefits to be paid; repealing 36 O.S. 2001, Section 627, which relates to the authorization of insurers; providing for codification; and providing an effective date.

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

SECTION 1. AMENDATORY 36 O.S. 2001, Section 348.1, as amended by Section 4, Chapter 307, O.S.L. 2002 (36 O.S. Supp. 2004, Section 348.1), is amended to read as follows:

Section 348.1 A. The Insurance Commissioner shall collect the following fees and licenses for the Board and the Property and Casualty Division:

1. Rating organizations, application fee
for issuance of license..... $200.00

2. Miscellaneous:

a. Certificate of Insurance Commissioner,
under seal..... .$20.00

b. Upon each transaction of filing of
documents required pursuant to the
provisions of Section 3610 of this title:

(1) For an individual insurer..... $50.00

(2) For an approved rating or advisory
organization:

(a) Basic fee..... $50.00

(b) Additional fee for each
member or subscriber insurer..... $10.00,
not to exceed..... $500.00

3. For each rate, loss cost and rule filing request pursuant to the provisions of Sections 902.1, 903 et seq., and 981 et seq. of this title:

a. For an individual insurer.....$100.00

b. For an approved rating or advisory
organization:

(1) Basic fee.....$100.00

(2) Additional fee for each member
or subscriber insurer.....$10.00,

not to exceed.....$500.00.

B. All fees and licenses collected by the Insurance Commissioner as provided in this section shall be paid into the State Treasury on a weekly basis to the credit of the Insurance Commissioner's Revolving Fund for the purpose of carrying out and enforcing the provisions of Article 9 of the Insurance Code.

C. The fees, licenses, and taxes imposed by the Board or the Commissioner upon persons, firms, associations, or corporations licensed pursuant to this section shall be payment in full with respect thereto of and in lieu of all demands for any and all state, county, district, and municipal license fees, license taxes, business privilege taxes, business privilege fees, and charges of every kind now or hereafter imposed upon all such persons, firms, associations, or corporations. This subsection shall not affect other fees, licenses and taxes imposed by the Insurance Code.

D. Any costs incurred by the Board or the Commissioner in the process of review and analysis of a filing shall be assessed against the company or organization making the filing.

SECTION 2. AMENDATORY Section 3, Chapter 274, O.S.L. 2004 (36 O.S. Supp. 2004, Section 615.2), is amended to read as follows:

Section 615.2 All domestic insurers and health maintenance organizations are required to keep biographical information current. ~~A domestic insurer is~~ Domestic insurers and health maintenance organizations are required to provide Biographical Affidavits within thirty (30) days of any change in officers, directors, key management or any person acquiring ten percent (10%) or more controlling interest in a domestic insurer. The information shall be on the National Association of Insurance Commissioners (NAIC) UCAA Biographical Affidavit Form. The Biographical Affidavit is to be certified by an independent third party acceptable to the Insurance Commissioner that has conducted a comprehensive review of

the background of the applicant and has indicated that the Biographical Affidavit has no significantly inaccurate or conflicting information and is accepted as the Business Character Report. As used in this section, "independent third party" is one that has no affiliation with the applicant and is in the business of providing background checks or investigations. The Business Character Report must be current and shall not be older than one (1) year.

SECTION 3. AMENDATORY 36 O.S. 2001, Section 629, as amended by Section 4, Chapter 274, O.S.L. 2004 (36 O.S. Supp. 2004, Section 629), is amended to read as follows:

Section 629. A. Every insurance company transacting business in this state whose premium tax, paid with respect to the previous calendar year's premiums, was One Thousand Dollars ($1,000.00) or more, shall make an estimate each year as provided herein and remit with each estimate a prepayment of its annual premium tax for the current calendar year equal to one-fourth (1/4) of its annual premium tax paid with respect to the previous calendar year's premiums. Estimates, with remittance, shall be made on or before April ~~1~~ 15, June 15, September 15 and December 15, respectively.

B. All sums prepaid by an insurance company shall be allowed as credits against its annual return for premium tax payable on or before the first day of March. If sums prepaid exceed the insurance company's annual premium tax payable on or before the first day of March, the excess shall be refunded or shall be allowed as credits against subsequent prepayments of the tax as the insurance company shall elect on the annual return for premium tax filed for the year by the insurance company with respect to which such excess prepayments were made. Provided, in the case of an insurance company which has made prepayments of its premium tax in excess of its annual premium tax payable, the part of the excess prepayments as has not been credited against subsequent prepayments of the tax

shall be refunded to the insurance company upon application within one hundred eighty (180) days after application is made.

SECTION 4. AMENDATORY 36 O.S. 2001, Section 903, as amended by Section 7, Chapter 519, O.S.L. 2004 (36 O.S. Supp. 2004, Section 903), is amended to read as follows:

Section 903. A. 1. ~~Except as to inland marine risks which by general custom of the business are not written according to manual rates or rating plans, every~~ Every insurer governed by the provisions of this act shall file with the Board, either directly or through a licensed rating organization of which it is a member or subscriber, all rates and rating plans and classifications, class rates, rating schedules, loss cost and all other supplementary rate information and every modification of any of the foregoing, which it uses or proposes to use in this state except as otherwise provided in this section.

2. The Board shall send a notification of filing of rates to any person who annually requests, in writing, to be notified of filings pursuant to regulation of the Board.

3. The Attorney General shall be notified within ten (10) days, in writing, of each:

a. filing of rates, whether for prior approval or for immediate use, and

b. certification of completion of a filing.

4. The Attorney General shall be notified at least ten (10) days in advance, in writing, of each:

a. meeting of the Board, and

b. hearing conducted by the Board.

B. Rates, rating plans, classifications, schedules, loss cost and other information shall be deemed approved ~~thirty (30)~~ ninety (90) calendar days following certification of completion of the filing as provided in this act unless, within the ~~thirty (30)~~ ninety-calendar-day period:

1. The Board by majority vote, approves, disapproves or approves with modification, the filing at one of its scheduled meetings or hearings;

2. The Board orders a formal hearing on the filing; or

3. The Board or the Commissioner, if a quorum of the Board is not available at the next regularly scheduled meeting, extends this period for one additional ~~thirty (30)~~ ninety-calendar-day period.

C. Nothing in this act shall be construed to require any filing for approval of rates, rating plans, classifications, schedules, loss cost and other information approved by the Board prior to ~~the effective date of this act~~ July 1, 1987.

D. Any formal hearing ordered by the Board shall be completed and a written order on the filing issued by the Board within ~~ninety (90)~~ one hundred twenty (120) calendar days from the date of the order setting the formal hearing, or the filing shall be deemed approved at the expiration of the ~~ninety-day~~ one-hundred-twenty-day period.

E. Rates or risks which are not by general custom of the business, or because of rarity or peculiar characteristics, written according to normal classification or rating procedure and which cannot be practicably filed before they are used, may be used before being filed. The Board may make such examination as it may deem advisable to ascertain whether any such rates meet the requirements of this act.

F. Whenever it shall be made to appear to the Board, either from its own information or from complaint of any party alleging to be aggrieved thereby, that there are reasonable grounds to believe that the rates on any or on all risks or classes of risks or kinds of insurance within the scope of this article are not in accordance with the terms of this act, it shall be the duty of the Board to investigate and determine whether or not any or all of such rates meet the requirements of this act.

G. When investigating rates to determine whether or not they comply with the provisions of this act, the previously approved filing shall not be changed, altered, amended, or held in abeyance until after completion of the investigation and an opportunity for hearing in accordance with the provisions of this article. Following such hearing, the Board shall enter its order in accordance with the provisions of this act. The effective date of such order shall not be less than thirty (30) days nor more than sixty (60) days after the date of the order unless the Board determines that, in the public interest, a shorter or longer period is appropriate; provided, the filer has adequate time to implement such rate change. Any such order shall apply prospectively only and shall not affect premiums collected on new or renewal policies issued prior to the effective date of this order.

H. Under such rules and regulations as it shall adopt, the Board may, by written order, suspend or modify the requirements of filing as to any kind of insurance, subdivision or combination thereof, or as to classes of risks, the rates for which cannot practicably be filed before they are used. Such orders, rules and regulations shall be made known to insurers and rating organizations affected thereby. The Board may make such examination as it may deem advisable to ascertain whether any rates affected by such order meet the standards set forth in this act. This subsection shall not apply to workers' compensation filings.

I. ~~Any filing with respect to fidelity, surety or guaranty bonds shall, however, be deemed approved from the date of filing.~~

~~J.~~ If the Board finds that a filing does not meet the requirements of this act, it shall send to the insurer or rating organization which made such filing, written notice of disapproval of such filing, specifying therein in what respects it finds that such filing fails to meet the requirements of this act and stating

that such filing shall not become effective to the extent disapproved.

SECTION 5. AMENDATORY 47 O.S. 2001, Section 11-801b, as renumbered by Section 35, Chapter 397, O.S.L. 2002 (36 O.S. Supp. 2004, Section 944), is amended to read as follows:

Section 944. No insurer shall, directly or indirectly, use traffic tickets or convictions for traffic offenses as a basis for cancellation of automobile insurance policies or increasing insurance premium rates for automobile insurance policies where such ticket or conviction is for exceeding the speed limit specified in ~~this act~~ Article 8 of Chapter 11 of Title 47 of the Oklahoma Statutes, but not exceeding the speed limit previously in force where the violation occurred; nor shall any insurer in any way penalize or adversely affect any insured for any such violation or conviction.

SECTION 6. AMENDATORY 36 O.S. 2001, Section 987, as amended by Section 19, Chapter 519, O.S.L. 2004 (36 O.S. Supp. 2004, Section 987), is amended to read as follows:

Section 987. Rate Filings.

A. In a competitive market, every insurer shall file with the Commissioner all rates and supplementary rate information to be used in this state no later than thirty (30) days after the effective date; provided, that the rates and supplementary rate information need not be filed for commercial risks, which by general custom are not written according to manual rules or rating plans.

B. In a noncompetitive market, every insurer shall file with the Commissioner all rates, supplementary rate information and supporting information at least thirty (30) days before the proposed effective date. The Commissioner may give written notice, within thirty (30) days of receipt of the filing, that the Commissioner needs additional time, not to exceed thirty (30) days from the date of the notice to consider the filing. Upon written application of

the insurer, the Commissioner may authorize rates to be effective before the expiration of the waiting period or an extension thereof. A filing shall be deemed to meet the requirements of the Property and Casualty Competitive Loss Cost Rating Act and to become effective unless disapproved pursuant to Section 988 of this title by the Commissioner before the expiration of the waiting period or an extension thereof.

In a noncompetitive market, the filing shall be deemed in compliance with the filing provision of this section unless the Commissioner informs the insurer within ten (10) days after receipt of the filings as to what supplementary rate information or supporting information is required to complete the filing.

C. Every authorized insurer shall file with the Commissioner, except as to rates for those lines of insurance exempted from the provisions of the Property and Casualty Competitive Loss Cost Rating Act by the Commissioner under subsections E and F of this section and except for those risks designated as special risks under Section 997 of this title, all rates, supplementary rate information and any changes and amendments which it proposes to use. An insurer may file its rates by either filing its final rates or by filing a multiplier and, if applicable, an expense constant adjustment to be applied to prospective loss costs that have been filed by an advisory organization as permitted by Section 993 of this title. Such loss cost multiplier filing and expense constant filings made by insurers shall remain in effect until amended or withdrawn by the insurer. Every filing shall state the effective date.

D. Under rules as may be adopted, the Commissioner may, by written order, suspend or modify the requirement of filing as to any kind of insurance, subdivision or combination thereof, or as to classes of risks.

E. Notwithstanding any other provision of the Property and Casualty Competitive Loss Cost Rating Act, upon the written consent

of the insured in a separate written document, a rate in excess of that determined in accordance with the other provisions of the Property and Casualty Competitive Loss Cost Rating Act may be used on a specific ~~commercial~~ risk.

F. A filing and any supporting information required to be filed shall be open to public inspection once the filing becomes effective except information marked confidential, trade secret, or proprietary by the insurer or filer.

SECTION 7. AMENDATORY 36 O.S. 2001, Section 991, is amended to read as follows:

Section 991. Licensing Advisory Organizations.

A. No advisory organization shall provide any service relating to the rates of any insurance subject to the ~~Commercial~~ Property and Casualty Competitive Loss Cost Rating Act, and no insurer shall utilize the services of such organization unless the organization has obtained a license.

B. No advisory organization shall refuse to supply any services for which it is licensed in this state to any insurer authorized to do business in this state and offering to pay the usual compensation for the services.

C. 1. An advisory organization applying for a license shall include with its application:

a. a copy of its constitution, charter, articles of organization, agreement, association or incorporation, and a copy of its bylaws, plan of operation and any other rules or regulations governing the conduct of its business,

b. a list of its members and subscribers,

c. the name and address of one or more residents of this state upon whom notices, process affecting it, or orders of the Commissioner may be served,

d. a statement showing its technical qualifications for acting in the capacity for which it seeks a license,

e. a biography of the ownership and management of the organization, and

f. any other relevant information and documents that the Commissioner may require.

2. Every organization which has applied for a license shall notify the Commissioner of every material change in the facts or in the documents on which its application was based. Any amendment to a document filed under this section shall be filed at least thirty (30) days before it becomes effective.

3. If the Commissioner finds that the applicant and the natural persons through whom it acts are competent, trustworthy and technically qualified to provide the services proposed, and that all requirements of the law are met, he or she shall issue a license specifying the authorized activity of the applicant. The Commissioner shall not issue a license if the proposed activity would tend to create a monopoly or to substantially lessen the competition in the market.

4. Licenses issued pursuant to this section shall remain in effect unless suspended or revoked. The Commissioner may at any time, after a hearing, revoke or suspend the license of any advisory organization which does not comply with the requirements and standards of the ~~Commercial~~ Property and Casualty Competitive Loss Cost Rating Act.

SECTION 8. AMENDATORY 36 O.S. 2001, Section 992, is amended to read as follows:

Section 992. Insurers and Advisory Organization; Prohibited Activity.

A. No insurer or advisory organization shall:

1. Attempt to monopolize, or combine or conspire with any person or persons to monopolize an insurance market;

2. Engage in a boycott, on a concerted basis, of an insurance market; and

3. Except as set forth in subsection B of this section, agree to mandate adherence to or to mandate use of any rate, prospective loss cost, rating plan, rating schedule, rating rule, policy or bond form, rate classification, rate territory, underwriting rule, survey, inspection or similar material. Insurers and advisory organizations may agree to develop and adhere to statistical plans permitted by Section ~~13~~ 993 of this ~~act~~ title.

B. The fact that two or more insurers, whether or not members or subscribers of an advisory organization, use consistently or intermittently the same rates, prospective loss costs, rating plans, rating schedules, rating rules, policy or bond forms, rate classifications, rate territories, underwriting rules, surveys or inspections or similar materials is not sufficient in itself to support a finding that an agreement exists.

C. Two or more insurers having a common ownership or operating in this state under common management or control may act in concert between or among themselves with respect to any matters pertaining to those activities authorized in the ~~Commercial~~ Property and Casualty Competitive Loss Cost Rating Act as if they constituted a single insurer.

D. Except as specifically permitted under Section ~~13~~ 993 of this ~~act~~ title, no advisory organization shall compile or distribute recommendations relating to rates that include expenses (other than loss adjustment expenses or loss-based taxes and assessments) or profit.

SECTION 9. AMENDATORY 36 O.S. 2001, Section 1204, is amended to read as follows:

Section 1204. The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

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

2. False information and advertising generally. Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in 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. No insurance company shall issue, or cause to be issued, any policy of insurance of any type or description upon life, or property, real or personal, whenever such policy of insurance is to be furnished or delivered to the purchaser or bailee of any property, real or personal, as an inducement to purchase or bail said property, real or personal, and no other

person shall advertise, offer or give free insurance, insurance without cost or for less than the approved or customary rate, in connection with the sale or bailment of real or personal property, except as provided in subsection B, Section 4101 of Article 41 (Group Life Insurance and Group Annuity Contracts). No person that is not an insurer shall assume or use any name which deceptively infers or suggests that it is an insurer.

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

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

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

Making any false entry in any book, report or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to whom such insurer is required by law to report, or who has authority by law to examine into its condition or into any of its affairs, or, with like intent, willfully omitting to

make a true entry of any material fact pertaining to the business of such insurer in any book, report or statement of such insurer.

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

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

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

(c) As to kinds of insurance other than life and accident and health, no person shall make or permit any unfair discrimination in favor of particular persons, or between insureds or subjects of insurance having substantially like insuring, risk, and exposure factors, or expense elements, in the terms or conditions of any insurance contract, or in the rate or amount of premium charged therefor. This subsection shall not apply as to any premium rate in effect pursuant to Article 9 of the Insurance Code.

8. Rebates. (a) 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 contract issued thereon; or paying or allowing, or

giving or offering to pay, allow or give, directly or indirectly, as inducement to any contract of insurance, 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; except in accordance with an applicable rate filing, rating plan or rating system filed with and approved by the Board or filed with and approved by the Commissioner; or giving or selling or purchasing or offering to give, sell, or purchase as inducement to such insurance, or in connection therewith, any stocks, bonds or other securities of any company, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract or receiving or accepting as inducement to contracts of insurance, any rebate of premium payable on the contract, or any special favor or advantage in the dividends or other benefit to accrue thereon, or any valuable consideration or inducement not specified in the contract.

(b) Nothing in subsection 7 or paragraph (a) of this subsection shall be construed as including within the definition of discrimination or rebates any of the following practices:

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

(2) In the case of life or accident and health insurance policies issued on the industrial debit or weekly premium 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 expense;

(3) Making a readjustment of the rate of premium for a policy based on the loss or expense experience 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;

(4) In the case of life insurance companies, allowing its bona fide employees to receive a commission on the premiums paid by them on policies on their own lives;

(5) Issuing life or accident and health policies on a salary saving or payroll deduction plan at a reduced rate commensurate with the savings made by the use of such plan;

(6) Paying commissions or other compensation to duly licensed agents or brokers, or allowing or returning to participating policyholders, members or subscribers, dividends, savings or unabsorbed premium deposits.

(c) As used in this section, the word "insurance" includes suretyship and the word "policy" includes bond.

9. Coercion prohibited. Requiring as a condition precedent to the purchase of, or the lending of money upon the security of, real or personal property, that any insurance covering such property, or liability arising from the ownership, maintenance or use thereof, be procured by or on behalf of the vendee or by the borrower in connection with such purchase or loan through any particular person or agent or in any particular insurer, or requiring the payment of a reasonable fee as a condition precedent to the replacement of insurance coverage on mortgaged property at the anniversary date of the policy; provided, however, that this provision shall not prevent the exercise by any such vendor or lender of the right to approve or disapprove any insurer selected to underwrite the insurance; but any disapproval of any insurer shall be on reasonable grounds.

10. Inducements. No insurer, agent, broker, solicitor, or other person shall, as an inducement to insurance or in connection with any insurance transaction, provide in any policy for or offer,

sell, buy, or offer or promise to buy, sell, give, promise, or allow to the insured or prospective insured or to any other person in his behalf in any manner whatsoever:

(a) Any employment.

(b) Any shares of stock or other securities issued or at any time to be issued or any interest therein or rights thereto.

(c) Any advisory board contract, or any similar contract, agreement or understanding, offering, providing for, or promising any special profits.

(d) Any prizes, goods, wares, merchandise, or tangible property of an aggregate value in excess of Twenty-five Dollars ($25.00).

(e) Any special favor, advantage or other benefit in the payment, method of payment or credit for payment of the premium through the use of credit cards, credit card facilities, credit card lists, or wholesale or retail credit accounts of another person. The provisions of this paragraph shall not apply to individual policies insuring against loss resulting from bodily injury or death by accident as defined by Article 44 of the Oklahoma Insurance Code.

11. Premature disposal of premium notes prohibited. No insurer or agent thereof shall hypothecate, sell, or dispose of a promissory note received in payment of any part of a premium on a policy of insurance applied for prior to the delivery of the policy.

12. Fraudulent statement in application; penalty. Any insurance agent, examining physician, or other person who knowingly or willfully makes a false or fraudulent statement or representation in or relative to an application for insurance, or who makes any such statement to obtain a fee, commission, money, or benefit shall be guilty of a misdemeanor.

SECTION 10. AMENDATORY 36 O.S. 2001, Section 1435.35, is amended to read as follows:

Section 1435.35 No insurer, insurance agent, surplus lines insurance broker, or limited insurance representative shall pay,

directly or indirectly, any commission, brokerage, or other valuable consideration to any person for services as an insurance agent, surplus lines insurance broker, or limited insurance representative within this state unless the person performing services held at the time said services were performed a valid license for such services as required by the laws of this state. No person other than a person duly licensed by this state as an insurance agent, surplus lines insurance broker, or limited insurance representative at the time said services were performed shall accept any commission, brokerage, or other valuable consideration. Any person duly licensed as an insurance agent pursuant to the provisions of the ~~Insurance Agents~~ Producer Licensing Act, Article 14A of this title, may pay or assign his or her commissions or direct that his or her commissions be paid to an entity licensed as an insurance agent pursuant to the provisions of this section of which the licensee is a member, partner, officer, employee, or agent. The provisions of this section shall not prevent payment or receipt of renewal or other deferred commissions to or by any person entitled thereto pursuant to the provisions of this section. Any person duly licensed as a limited insurance representative may pay or assign his or her commissions or direct that his or her commissions be paid to a financial institution or supervised lender licensed and regulated pursuant to the laws of this state or of any state or of the United States, or to any principal, corporation, partnership or other entity which is the credit granting party in any credit transaction involved, its parent, affiliate, successor or assign, or to a partnership or corporation licensed as a limited insurance representative of which the licensee is a member, officer, employee or agent.

SECTION 11. AMENDATORY 36 O.S. 2001, Section 1616, is amended to read as follows:

Section 1616. A. Any domestic company, in addition to other investments permitted by this article, may invest ~~an amount not to exceed its capital and surplus if a stock company, and if a company other than stock an amount not to exceed its surplus over all liabilities, directly or indirectly, in the shares of one or more insurance companies where such companies operate as companion companies or are under substantially the same management. The stock of another insurance company shall not be used by any company as assets in meeting the minimum requirements for organization of an insurance company~~ in common stock, preferred stock, debt obligations, and other securities of one or more subsidiaries, in amounts which do not exceed the lesser of ten percent (10%) of the assets of the insurer or fifty percent (50%) of the surplus of the insurer in regards to policyholders except instances where a greater investment has been approved by the Commissioner.

B. Except with the consent of the Insurance Commissioner, no domestic ~~life~~ insurer shall, in addition to other investments permitted by this article, invest an amount equal in the aggregate to more than ten percent (10%) of its assets~~, or in the case of a domestic nonlife insurer, an amount equal in the aggregate to more than twenty percent (20%) of its assets~~ in the shares of solvent corporations created or existing under the laws of the United States or of any state~~, including the shares of a substantially owned or wholly owned subsidiary corporation~~. Investing in the shares of mutual funds that invest only in bonds or preferred stocks shall be considered as investing in bonds or preferred stocks, and investing in mutual funds that invest in common stocks shall be considered as investing in common stocks. ~~However, investments in the shares of subsidiaries or companion insurance companies shall be governed by paragraph A of this section.~~

C. For the purpose of determining the investment limitation imposed by this article, the insurer shall value securities

purchased pursuant to the provisions of this article at the cost of the security or at the market value of the security, whichever is lower.

SECTION 12. AMENDATORY 36 O.S. 2001, Section 1655, is amended to read as follows:

Section 1655. (a) Transactions with Affiliates. Material transactions by registered insurers with their affiliates shall be subject to the provisions of Section 1604 of this title. The board of directors will be charged with exercising that degree of care which a prudent person would have exercised under similar circumstances. Material transactions shall be subject to the following standards:

(1) the terms shall be fair and reasonable;

(2) ~~the books, accounts and records of each party shall be so maintained as to clearly and accurately disclose the precise nature and details of the transaction~~ charges or fees for services performed shall be reasonable; ~~and~~

(3) expenses incurred and payment received shall be allocated to the insurer in conformity with customary insurance accounting practices consistently applied;

(4) the books, accounts and records of each party to all such transactions shall be so maintained as to clearly and accurately disclose the precise nature and details of the transaction including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties; and

(5) the insurer's surplus as regards policyholders following any dividends or distributions to shareholder affiliates shall be reasonable in relation

to the insurer's outstanding liabilities and adequate to meet its financial needs.

(b) Insurance Commissioner's Approval Required.

(1) The prior written approval of the Commissioner shall be required for the following transactions between a domestic insurer and its affiliates: sales, guarantees, purchases, exchanges, loans or extensions of credit or investments which, based upon an annual aggregate, involve more than ~~five percent (5%)~~ three percent (3%) of the insurer's admitted assets or twenty-five percent (25%) of the insurer's surplus as regards policyholders, whichever is less, as of the latest statutory financial statement filed with the Commissioner; provided, however, that the Commissioner must either approve or disapprove within thirty (30) days after receiving written notification from the insurer of the proposed transaction and failure to disapprove the proposed transaction within thirty (30) days shall constitute approval of the transaction;

(2) The prior written approval of the Commissioner shall be required for any transactions between a domestic insurer and its affiliates where the insurer is found by the Commissioner to be in unsound condition or in such condition as to render its further transaction of insurance in Oklahoma hazardous to its policyholders or to the people of Oklahoma; provided, however, that the Commissioner must either approve or disapprove within ninety (90) days after written notification by the insurer and failure to disapprove the proposed transaction within ninety (90) days shall constitute approval of the transaction;

(3) The following transactions involving a domestic insurer and any person in its holding company system may not be entered into unless the insurer has notified the Commissioner in writing of its intention to enter into such transaction at least thirty (30) days prior thereto, or such shorter period as the Commissioner may permit, and the Commissioner has not disapproved it within such period.

(i) loans or extensions of credit to any person who is not an affiliate, where the insurer makes such loans or extensions of credit with the agreement or understanding that the proceeds of such transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase assets of, or to make investments in, any affiliate of the insurer making such loans or extensions of credit provided such transactions are equal to or exceed: (a) with respect to nonlife insurers, the lesser of three percent (3%) of the insurer's admitted assets or twenty-five percent (25%) of surplus as regards policyholders; (b) with respect to life insurers, three percent (3%) of the insurer's admitted assets; each as of the 31st day of December next preceding;

(ii) reinsurance agreements or modifications thereto in which the reinsurance premium or a change in the insurer's liabilities equals or exceeds five percent (5%) of the insurer's surplus as regards policyholders, as of the 31st day of December next preceding, including those agreements which may require as consideration the transfer of

assets from an insurer to a nonaffiliate, if an agreement or understanding exists between the insurer and nonaffiliate that any portion of such assets will be transferred to one or more affiliates of the insurer;

(iii) all management agreements, service contracts and all cost-sharing arrangements; and

(4) The Insurance Commissioner shall promulgate reasonable rules and regulations governing the form and content of the notice required pursuant to subsection (b) of this section.

(c) Nothing in this section shall supersede approvals granted under other sections of this title or transactions occurring prior to the effective date of this section.

(d) Adequacy of Surplus. For purposes of Section 1651 et seq. of this title, in determining whether an insurer's surplus as regards policyholders is reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs, the following factors, among others, shall be considered:

(1) the size of the insurer as measured by its assets, capital and surplus, reserves, premium writing, insurance in force and other appropriate criteria;

(2) the extent to which the insurer's business is diversified among the several lines of insurance;

(3) the number and size of risks insured in each line of business;

(4) the extent of the geographical dispersion of the insurer's insured risks;

(5) the nature and extent of the insurer's reinsurance program;

(6) the quality, diversification, and liquidity of the insurer's investment portfolio;

(7) the recent past and projected future trend in the size of the insurer's investment portfolio;

(8) the surplus as regards policyholders maintained by other comparable insurers;

(9) the adequacy of the insurer's reserves;

(10) the quality and liquidity of investments in subsidiaries made pursuant to Section 1652 of this title. The Commissioner may treat any such investment as a disallowed asset for purposes of determining the adequacy of surplus as regards policyholders whenever in his judgment such investment so warrants; and

(11) the quality of the insurer's earnings and the extent to which the reported earnings include extraordinary items.

(e) Dividends and Other Distributions. No insurer subject to registration under Section 1654 of this title shall pay any extraordinary dividend or make any other extraordinary distribution to its shareholders until (i) thirty (30) days after the Commissioner has received notice of the declaration thereof and has not within such period disapproved such payment, or (ii) the Commissioner shall have approved such payment within such thirty-day period.

For purposes of this section, an extraordinary dividend or distribution includes any dividend or distribution of cash or other property, whose fair market value together with that of other dividends or distributions made within the preceding twelve months exceeds the greater of (i) ten percent (10%) of such insurer's surplus as regards policyholders as of the 31st day of December next preceding, or (ii) the net gain from operations of such insurer, if such insurer is a life insurer, or the net income, if such insurer is not a life insurer, not including realized capital gains, for the twelve-month period ending the 31st day of December next preceding,

but shall not include pro rata distributions of any class of the insurer's own securities.

Notwithstanding any other provision of law, an insurer may declare an extraordinary dividend or distribution which is conditional upon the Commissioner's approval thereof, and such a declaration shall confer no rights upon shareholders until (i) the Commissioner has approved the payment of such dividend or distribution or (ii) the Commissioner has not disapproved such payment within the thirty-day period referred to above.

SECTION 13. AMENDATORY 36 O.S. 2001, Section 3639, is amended to read as follows:

Section 3639. A. The provisions of this section apply to commercial property insurance policies, commercial casualty insurance policies, and commercial fire insurance policies.

B. As used in this section:

1. "Renewal" or "to renew" means the issuance or offer of issuance by an insurer of a policy succeeding a policy previously issued and delivered by the same insurer or an insurer within the same group of insurers, or the issuance of a certificate or notice extending the term of an existing policy for a specified period beyond its expiration date;

2. "Nonpayment of premium" means the failure or inability of the named insured to discharge any obligation in connection with the payment of premiums on a policy of insurance subject to this section, whether such payments are payable directly to the insurer or its agent or indirectly payable under a premium finance plan or extension of credit;

3. "Cancellation" means termination of a policy at a date other than its expiration date;

4. "Expiration date" means the date upon which coverage under a policy ends. It also means, for a policy written for a term longer

than one (1) year or with no fixed expiration date, each annual anniversary date of such policy; and

5. "Nonrenewal" or "refusal to renew" means termination of a policy at its expiration date.

C. After coverage has been in effect for more than forty-five (45) business days or after the effective date of the renewal of a commercial property, commercial casualty or commercial fire insurance policy, a notice of cancellation shall not be issued by any licensed insurer or surplus or excess lines insurer unless it is based on at least one of the following reasons with at least ten (10) days notice to the insured:

1. Nonpayment of premium;

2. Discovery of fraud or material misrepresentation in the procurement of the insurance or with respect to any claims submitted thereunder;

3. Discovery of willful or reckless acts or omissions on the part of the named insured which increase any hazard insured against;

4. The occurrence of a change in the risk which substantially increases any hazard insured against after insurance coverage has been issued or renewed;

5. A violation of any local fire, health, safety, building, or construction regulation or ordinance with respect to any insured property or the occupancy thereof which substantially increases any hazard insured against;

6. A determination by the Commissioner that the continuation of the policy would place the insurer in violation of the insurance laws of this state;

7. Conviction of the named insured of a crime having as one of its necessary elements an act increasing any hazard insured against; or

8. Loss of or substantial changes in applicable reinsurance.

D. An insurer may refuse to renew a policy if the insurer gives to the first-named insured at the address shown on the policy written notice that the insurer will not renew the policy. Such notice shall be given at least forty-five (45) days before the expiration date. If notice is given by mail, said notice shall be deemed to have been given on the day said notice is mailed. If the notice is mailed less than forty-five (45) days before expiration, coverage shall remain in effect until forty-five (45) days after notice is mailed. Earned premium for any period of coverage that extends beyond the expiration date shall be considered pro rata based upon the previous year's rate. For purposes of this section, the transfer of a policyholder between companies within the same insurance group is not a refusal to renew. In addition, changing deductibles, changes in premium, changes in the amount of insurance, or reductions in policy limits or coverage are not refusals to renew.

Notice of nonrenewal shall not be required if the insurer or a company within the same insurance group has offered to issue a renewal policy or, if the named insured has obtained replacement coverage or has agreed in writing to obtain replacement coverage.

If an insurer provides the notice required by this subsection and thereafter the insurer extends the policy for ninety (90) days or less, an additional notice of nonrenewal is not required with respect to the extension.

E. An insurer shall give to the named insured at the mailing address shown on the policy, written notice of premium increase, change in deductible, reduction in limits or coverage at least forty-five (45) days prior to the expiration date of the policy. If the insurer fails to provide such notice, the premium, deductible, limits and coverage provided to the named insured prior to the change shall remain in effect until notice is given or until the effective date of replacement coverage obtained by the named

insured, whichever first occurs. If notice is given by mail, said notice shall be deemed to have been given on the day said notice is mailed. If the insured elects not to renew, any earned premium for the period of extension of the terminated policy shall be calculated pro rata at the lower of the current or previous year's rate. If the insured accepts the renewal, the premium increase, if any, and other changes shall be effective the day following the prior policy's expiration or anniversary date.

This subsection shall not apply to:

1. Changes in a rate or plan filed with or approved by the State Board for Property and Casualty Rates or filed pursuant to the ~~Commercial~~ Property and Casualty Competitive Loss Cost Rating Act and applicable to an entire class of business; or

2. Changes based upon the altered nature of extent of the risk insured; or

3. Changes in policy forms filed with or approved by the Insurance Commissioner and applicable to an entire class of business.

F. Proof of mailing of notice of cancellation, or of nonrenewal or of premium or coverage changes, to the named insured at the address shown in the policy, shall be sufficient proof of notice.

SECTION 14. AMENDATORY 36 O.S. 2001, Section 4101, is amended to read as follows:

Section 4101. No policy of group life insurance shall be delivered in this state unless it conforms to one of the following descriptions:

1. A policy issued to an employer, or to the trustees of a fund established by an employer, which employer or trustees shall be deemed the policyholder, to insure employees of the employer for the benefit of persons other than the employer, subject to the following requirements:

a. The employees eligible for insurance under the policy shall be all of the employees of the employer, or all of any class or classes thereof determined by conditions pertaining to their employment. The policy may provide that the term "employees" shall include the employees of one or more subsidiary corporations, and the employees, individual proprietors and partners of one or more affiliated corporations, proprietors or partnerships if the business of the employer and of such affiliated corporations, proprietors or partnerships is under common control through stock ownership or contract, or otherwise. The policy may provide that the term "employees" shall include the individual proprietor or partners if the employer is an individual proprietor or a partnership. The policy may provide that the term "employees" shall include retired employees. No director of a corporate employer shall be eligible for insurance under the policy unless such a person is otherwise eligible as a bona fide employee of the corporation by performing services other than the usual duties of a director. No individual proprietor or partner shall be eligible for insurance under the policy unless he is actively engaged in and devotes a substantial part of his time to the conduct of the business of the proprietor or partnership. The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship. A policy issued to insure the employees of a public body may provide that the term "employee" shall include elected or appointed officials.

b. The premium for the policy shall be paid by the policyholder, either wholly from the employer's funds or funds contributed by him, or partly from such funds and partly from funds contributed by the insured employees, or from funds contributed wholly by the insured employees. A policy on which part or all of the premium is to be derived from funds contributed by the insured employees may be placed in force only if at least seventy-five percent (75%) of the then eligible employees, excluding any as to whom evidence of individual insurability is not satisfactory to the insurer, elect to make the required contributions. A policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees, or all except any as to whom evidence of insurability is not satisfactory to the insurer.

c. ~~The policy must cover at least ten employees as of date of issue.~~

~~d.~~ The amounts of insurance under the policy must be based upon some plan precluding individual selection either by the employees or by the employer or trustee;

2. A policy issued to a creditor, who shall be deemed to be the policyholder, to insure debtors of the creditor. Credit unions and associations formed for the purpose of making loans to their members shall be deemed to be creditors within the meaning of this section. Policies issued to a creditor to insure debtors of the creditor are subject to the following requirements:

a. The debtors eligible for insurance under the policy shall be all of the debtors of the creditor or all of any class or classes thereof determined by conditions pertaining to the indebtedness or to the purchase

giving rise to the indebtedness. The policy may provide that the term "debtors" shall include the debtors of one or more subsidiary corporations, and the debtors of one or more affiliated corporations, proprietors or partnerships if the business of the policyholder and of such affiliated corporations, proprietors or partnerships is under common control through stock ownership, contract or otherwise.

b. The premium for the policy shall be paid by the policyholder, either from the creditor's funds, or from charges collected from the insured debtors, or from both. A policy on which part or all of the premium is to be derived from the collection from the insured debtors of identifiable charges not required of uninsured debtors shall not include, in the class or classes of debtors eligible for insurance, debtors under obligation outstanding at its date of issue without evidence of individual insurability unless at least seventy-five percent (75%) of the then eligible debtors elect to pay the required charges. A policy on which no part of the premium is to be derived from the collection of such identifiable charges must insure all eligible debtors, or all except any as to whom evidence of individual insurability is not satisfactory to the insurer.

c. The policy may be issued only if the group of eligible debtors is then receiving new entrants at the rate of at least one hundred persons yearly, or may reasonably be expected to receive at least one hundred new entrants during the first policy year, and only if the policy reserves to the insurer the right to require evidence of individual insurability if less than

seventy-five percent (75%) of the new entrants become insured.

d. The amount of insurance on the life of any debtor shall at no time exceed the amount owed by him which is repayable to the creditor, or One Hundred Thousand Dollars ($100,000.00), whichever is less, provided further, no company licensed to do business in this state shall issue in excess of One Hundred Thousand Dollars ($100,000.00) group credit life insurance on one individual in the State of Oklahoma.

e. The insurance shall be payable to the policyholder. Such payment shall reduce or extinguish the unpaid indebtedness of the debtor to the extent of such payment;

3. A policy issued to a labor union, which shall be deemed the policyholder, to insure members of such union for the benefit of persons other than the union or any of its officials, representatives or agents, subject to the following requirements:

a. The members eligible for insurance under the policy shall be all of the members of the union, or all of any class or classes thereof determined by conditions pertaining to their employment, or to membership in the union, or both.

b. The premium for the policy shall be paid by the policyholder, either wholly from the union's funds, or partly from such funds and partly from funds contributed by the insured members specifically for their insurance, or from funds contributed wholly by the insured members. A policy on which part or all of the premium is to be derived from funds contributed by the insured members specifically for their insurance may be placed in force only if at least seventy-five

percent (75%) of the then eligible members, excluding any as to whom evidence of individual insurability is not satisfactory to the insurer, elect to make the required contributions. A policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members or all except any as to whom evidence of individual insurability is not satisfactory to the insurer.

c. The policy must cover at least ten members at date of issue.

d. The amount of insurance under the policy must be based upon some plan precluding individual selection either by the members or by the union;

4. A policy issued to the trustees of a fund established in this state by two or more employers in the same industry, provided a majority of the employees to be insured of each employer are located within this state, or to the trustees of a fund established by one or more labor unions, or by one or more employers in the same industry and one or more labor unions or by one or more employers and one or more labor unions whose members are in the same or related occupation or trades, or by an association of persons, licensed by the State of Oklahoma to engage in a recognized profession, which trustees shall be deemed the policyholder to insure employees of the employers or members of the unions or members of an association of persons, licensed by the State of Oklahoma to engage in a recognized profession, for the benefit of persons other than the employers or the unions, or the association of persons, licensed by the State of Oklahoma to engage in a recognized profession, subject to the following requirements:

a. The persons eligible for insurance shall be all of the employees of the employers or all of the members of

the union, or all the members of an association of persons, licensed by the State of Oklahoma to engage in a recognized profession, or all of any class or classes thereof determined by conditions pertaining to their employment, or to membership in the unions, or to both, or pertaining to membership in the association of persons, licensed by the State of Oklahoma to engage in a recognized profession. The policy may provide that the term "employees" shall include the individual proprietor or partners if any employer is an individual proprietor or a partnership. The policy may provide that the term "employees" shall include retired employees. No director of a corporate employer shall be eligible for insurance under the policy unless such person is otherwise eligible as a bona fide employee of the corporation by performing services other than the usual duties of a director. No individual proprietor or a partner shall be eligible for insurance under the policy unless he is actively engaged in and devotes a substantial part of his time to the conduct of the business of the proprietor or partnership. The policy may provide that the term "employees" shall include the trustees or their employees, or both if their duties are principally connected with such trusteeship, and that the term "members of an association" shall include employees of members.

b. The premium for the policy shall be paid by the trustees wholly from funds contributed by the employer or employers of the insured persons, or by the union or unions, or by both, or by an association of persons, licensed by the State of Oklahoma to engage

in a recognized profession, or from funds contributed wholly or in part by the insured persons. A policy on which part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance may be placed in force only if at least seventy-five percent (75%) of the then eligible persons, excluding any as to whom evidence of insurability is not satisfactory to the insurer, elect to make the required contributions. A policy issued to the trustees of a fund established by an association of persons, licensed by the State of Oklahoma to engage in a recognized profession, on which part or all the premium is to be derived from funds contributed by the insured persons specifically for their insurance, may be placed in force only if the total number of persons covered at the date of issue exceeds six hundred or seventy-five percent (75%) of the eligible persons, whichever is less, excluding any as to whom evidence of insurability is not satisfactory to the insurer, elect to make the required contribution. A policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance must insure all eligible persons, or all except any as to whom evidence of individual insurability is not satisfactory to the insurer.

c. The policy must cover at date of issue at least one hundred persons; and if the fund is established by the members of an association of employers the policy may be issued only if (a) either (i) the participating employers constitute at date of issue at least sixty percent (60%) of those employer members whose

employees are not already covered by group life insurance or (ii) the total number of persons covered at date of issue exceeds six hundred; and (b) the policy shall not require that if a participating employer discontinues membership in the association, the insurance of his employees shall cease solely by reason of such discontinuance.

d. The amounts of insurance under the policy must be based upon some plan precluding individual selection either by the insured persons or by the policyholder, employers, or unions;

5. A policy issued to any nonprofit industrial association to insure the executives of employer members of a nonprofit industrial association, which is now and has been actively functioning for a period of not less than ten (10) years, such policy to be issued to such association which shall be deemed to be the employer for the purposes of this article, or to the association and executives of such employer members jointly and insuring only all of such executives for amounts of insurance based upon some plan which will preclude individual selection, for the benefit of persons other than such association, and the premium on which shall be paid by the employer members or the employer members and the executives of such employer members jointly;

6. A policy issued to a credit union which shall be deemed the policyholder, to insure eligible members for the benefit of someone other than the credit union or its officials and subject to the following requirements:

a. The members eligible for insurance under the policy shall be all the members of the credit union or all of any class or classes thereof.

b. The premiums for the policy shall be paid by the policyholder, either wholly from the credit union's

funds, or partly from such funds and partly from funds contributed by the insured members specifically for their insurance. A policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members or all except any as to whom evidence of individual insurability is not satisfactory to the insurer.

c. The amount of insurance under the policy may be based on the amount of the member's savings in the credit union or upon some other plan precluding individual selection either by the members or by the credit union;

7. A policy issued to a charitable, benevolent, educational or religious institution, or their agencies, to insure the members thereof for the purpose set forth in subsection D of Section 3604 of this title;

8. A policy issued to an alumni association of an institution of higher education accredited by the Oklahoma State Regents for Higher Education, to insure the members thereof for the purpose set forth in subsection E of Section 3604 of this title;

9. A policy to an association, which has a constitution and bylaws and which has been organized and is maintained in good faith for purposes other than that of obtaining insurance, that insures at least ten members, employees, or employees of members of the association or its officers or trustees. The term “employees” as used in this paragraph shall include retired employees.

“Association” means, with respect to life insurance coverage offered, an association which:

a. has been actively in existence for at least five (5) years,

b. has been formed and maintained in good faith for purposes other than obtaining insurance,

c. does not condition membership in the association on any health status-related factor relating to an individual, including an employee of an employer or a dependent of an employee or association member,

d. makes life insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such member or individuals eligible for coverage through a member,

e. does not make life insurance coverage offered through the association available other than in connection with a member of the association, and

f. meets such additional requirements as may be imposed under state law;

10. A policy issued to cover any other group subject to the following requirements:

a. no such group life insurance policy shall be delivered in this state unless the Commissioner of Insurance finds that:

(1) the issuance of such group policy is not contrary to the best interest of the public,

(2) the issuance of the group policy would result in economies of acquisition or administration, and

(3) the benefits are reasonable in relation to the premiums charged, and

b. the premium for the policy shall be paid either from the policyholder's funds or from funds contributed by the covered person or from both; or

11. A policy issued to cover any other substantially similar group which, in the discretion of the Insurance Commissioner, may be subject to the issuance of a group life policy or contract.

SECTION 15. AMENDATORY 36 O.S. 2001, Section 6402, is amended to read as follows:

Section 6402. The rates for such custom harvesting insurance shall be those rates on file with the ~~Board for Property and Casualty Rates~~ Insurance Commissioner on ~~the effective date of this act~~ May 15, 1986, or if such rates are not on file and need to be ~~filed and approved, such rates shall not be subject to the time constraints for rating approval as provided in the Insurance Code. Such rates may be immediately used pending approval by the Board for Property and Casualty Rates~~ submitted or filed with the Insurance Commissioner.

SECTION 16. AMENDATORY 36 O.S. 2001, Section 6418, is amended to read as follows:

Section 6418. Each member insurer shall use the filed ~~and approved~~ rate for the liability and homeowners' insurance being written ~~or those rates effective by Section 924 of this Code~~. Any variance from such rate, including a variance based upon debit, shall be ~~approved prior to use, by the State Board for Property and Casualty Rates~~ submitted or filed with the Insurance Commissioner.

SECTION 17. AMENDATORY Section 22, Chapter 390, O.S.L. 2003 (36 O.S. Supp. 2004, Section 6821), is amended to read as follows:

Section 6821.

MEDICAL PROFESSIONAL LIABILITY RATE SETTING

A. No rate shall be approved or remain in effect which is excessive, inadequate, unfairly discriminatory or otherwise in violation of this section. Notwithstanding any other provision of law, in considering whether a rate is excessive, inadequate or unfairly discriminatory, no consideration shall be given to the degree of competition and the Insurance Commissioner shall consider whether the rate mathematically reflects the insurance company's investment income.

B. Notwithstanding any other provision of law, every medical professional liability insurer which desires to change any rate shall file a rate application with the Commissioner. A complete rate application shall include the factors enumerated in Section 902.2 of ~~Title 36 of the Oklahoma Statutes~~ this title and such other information as the Commissioner may require. The applicant shall have the burden of proving that the requested rate change is justified and meets the requirements of this section.

C. The ~~Commissioner~~ insurer shall notify the policyholders of any application by an insurer for a rate change. The insurer shall file an affidavit signed by the individual responsible for the rate change application with the Commissioner certifying that policyholders were notified pursuant to this section. The application shall be deemed approved forty-five (45) days after notice unless:

1. A policyholder or the policyholder's representative requests a hearing within forty-five (45) days of the notice and the Commissioner, within fifteen (15) days thereafter, grants the hearing, or determines not to grant the hearing and issues written findings in support of that decision; or

2. The Commissioner on his or her own motion determines to hold a hearing.

In any event, a rate change application shall be deemed approved ninety (90) days after the rate application is received by the Commissioner unless that application has been disapproved by a final order of the Commissioner subsequent to a hearing or extraordinary circumstances exist. For purposes of this paragraph "received" means the date delivered to the Insurance Department.

D. For purposes of subsection C of this section, "extraordinary circumstances" include the following:

1. Rate change application hearings commenced during the ninety-day period provided by subsection C of this section. If a

hearing is commenced during the ninety-day period, the rate change application shall be deemed approved upon expiration of the ninety-day period or thirty (30) days after the close of the record of the hearing, whichever is later, unless disapproved prior to that date.

2. The hearing has been continued. The ninety-day period provided by subsection C of this section shall be tolled during any period of which a hearing is continued. A continuance shall be decided on a case by case basis. If the hearing is commenced or continued during the ninety-day period, the rate change application shall be deemed approved upon the expiration of the ninety-day period or thirty (30) days after the close of the record of the hearing, whichever is later, unless disapproved prior to that date.

E. No medical professional liability insurer shall cancel or refuse to renew coverage of a policyholder on the basis of a policyholder's exercise of any right pursuant to this section.

F. Nothing in this section shall apply to policies insuring any nursing home licensed pursuant to Section 1-1903 of Title 63 of the Oklahoma Statutes.

SECTION 18. AMENDATORY Section 6, Chapter 197, O.S.L. 2003 (36 O.S. Supp. 2004, Section 6906), is amended to read as follows:

Section 6906. A. A director, officer, employee or partner of a health maintenance organization who receives, collects, disburses or invests funds in connection with the activities of the organization shall be responsible for the funds in a fiduciary relationship to the organization.

B. A health maintenance organization shall maintain in force a fidelity bond or fidelity insurance on such employees, officers, directors and partners in an amount that is not less than Two Hundred Fifty Thousand Dollars ($250,000.00) for each health maintenance organization, or a maximum of ~~Five Thousand Dollars ($5,000.00)~~ <u>Five Million Dollars ($5,000,000.00)</u> in aggregate

maintained on behalf of health maintenance organizations owned by a common parent corporation, or the sum prescribed by the Insurance Commissioner.

SECTION 19. AMENDATORY Section 26, Chapter 197, O.S.L. 2003 (36 O.S. Supp. 2004, Section 6926), is amended to read as follows:

Section 6926. A. Except as otherwise provided in the Health Maintenance Organization Act of 2003 <u>or unless expressly made applicable to health maintenance organizations</u>, provisions of the insurance law and provisions of hospital or medical service corporation laws shall not be applicable to a health maintenance organization granted a certificate of authority under the provisions of this act. This provision shall not apply to an insurer or hospital or medical service corporation licensed and regulated pursuant to the insurance law or the hospital or medical service corporation laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to this act.

B. Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

C. Any health maintenance organization authorized under this act shall not be deemed to be practicing medicine and shall be exempt from the provisions of Title 59 of the Oklahoma Statutes related to the practice of medicine.

SECTION 20. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7001 of Title 36, unless there is created a duplication in numbering, reads as follows:

Sections 20 through 22 of this act shall constitute Article 70 of the Oklahoma Insurance Code and shall be known and may be cited as the "Health Savings Account Act". The purpose of this act is to

enable citizens of Oklahoma to establish health savings accounts as permitted by Section 223 of the Internal Revenue Code as added by Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. 108-173.

SECTION 21. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7002 of Title 36, unless there is created a duplication in numbering, reads as follows:

As used in this act:

1. "High deductible health plan" means a health plan which meets the requirements of Section 223(c)(2) of the Internal Revenue Code as added by Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. 108-173; and

2. "State-mandated benefits" means coverage for health care services or benefits, required by state law or state regulations, requiring the reimbursement or utilization related to a specific illness, injury, or condition of the covered person, or inclusion of a specific category of licensed health care practitioner to be provided to the covered person in a health benefit plan for a health-related condition of a covered person. Provided, that for the purposes of the options provided by this act, state-mandated health benefits which may be excluded in whole or in part shall not include any health care services or benefits which are mandated by federal law. "State-mandated health benefits" does not mean standard provisions or rights required to be present in a health benefit plan pursuant to state law or state regulations unrelated to a specific illness, injury or condition of the insured, including, but not limited to, those related to continuation of benefits found in Article 45 of the Oklahoma Insurance Code in Title 36 of the Oklahoma Statutes.

SECTION 22. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7003 of Title 36, unless there is created a duplication in numbering, reads as follows:

Any insurance company, health maintenance organization or group health service organization that files a high deductible health benefit plan pursuant to Section 223(c)(2) of the Internal Revenue Code as added by Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. 108-173, shall not be required to offer coverage for any state-mandated benefits as defined in Section 20 of this act.

SECTION 23. AMENDATORY 25 O.S. 2001, Section 307.1, as last amended by Section 14, Chapter 5, O.S.L. 2004 (25 O.S. Supp. 2004, Section 307.1), is amended to read as follows:

Section 307.1 A. No public body shall hold meetings by teleconference except:

1. Oklahoma Futures;

2. The Oklahoma State Regents for Higher Education;

3. The State Board of Medical Licensure and Supervision;

4. The State Board of Osteopathic Examiners;

5. The Board of Dentistry;

6. The Variance and Appeals Boards created in Sections 1021.1, 1697 and 1850.16 and the Construction Industries Board created in Section 1000.2 of Title 59 of the Oklahoma Statutes;

7. A public trust whose beneficiary is a municipality; however, no more than twenty percent (20%) of a quorum of the trustees may participate by teleconference and during any such meetings all votes shall be roll call votes;

8. The Native American Cultural and Educational Authority;

9. The Corporation Commission;

10. The State Board of Career and Technology Education;

11. The Oklahoma Funeral Board; ~~and~~

12. The District Attorneys Council<u>; and</u>

<u>13. The State Board of Property and Casualty Rates</u>.

B. A board of education of a technology center school district may hold meetings by videoconference where each board member is

visible to each other and the public through a video monitor, subject to the following:

1. No fewer than three members of a five-member board or four members of a seven-member board shall be present in person at the site of each meeting;

2. The public notice posted in advance of the meeting shall indicate such meeting will be conducted via videoconference;

3. Each site and room where members of the board are present for a meeting by videoconference shall be open and accessible to the public, and the public shall be allowed into the site and room; and

4. The public shall be allowed to participate or have input in a meeting at the videoconference site in the same manner and to the same extent as the public is allowed to participate or have input in a meeting at the site of the meeting.

C. No public body authorized to hold meetings by teleconference or videoconference shall conduct an executive session by teleconference or videoconference.

SECTION 24. AMENDATORY 85 O.S. 2001, Section 64, is amended to read as follows:

Section 64. A. Every policy of insurance covering the liability of the employer for compensation issued by a stock company or by a mutual association or other concern authorized to transact workers' compensation insurance in this state shall contain a provision setting forth the right of the Administrator to enforce in the name of the state, for the benefit of the person entitled to the compensation insured by the policy either by filing a separate application or by making the insurance carrier a party to the original application, the liability of the insurance carrier in whole or in part for the payment of such compensation; provided, however, that payment in whole or in part of the compensation by either the employer or the insurance carrier shall, to the extent

thereof, be a bar to the recovery against the other of the amount so paid.

B. Every such policy shall contain a provision that, as between the employee and the insurance carrier, the notice to or knowledge of the occurrence of the injury on the part of the employer shall be deemed notice or knowledge, as the case may be on the part of the insurance carrier, that jurisdiction of the employer shall, for the purpose incorporated in this title, be jurisdiction of the insurance carrier, and that the insurance carrier shall in all things be bound by and subject to the orders, findings, decisions or awards rendered against the employer for the payment of compensation under the provisions incorporated in this title.

C. Every such policy shall contain a provision to the effect that the insolvency or bankruptcy of the employer shall not relieve the insurance carrier from the payment of compensation for injuries sustained by an employee during the life of such policy.

D. 1. Every such policy issued to cover a risk in this state shall include provisions giving the insured employer the option of choosing a deductible amount for medical <u>or indemnity</u> benefits in amounts ranging from Five Hundred Dollars ($500.00) to Two Thousand Five Hundred Dollars ($2,500.00) in increments of Five Hundred Dollars ($500.00). The insured employer, if choosing to exercise the option, shall choose only one deductible amount.

2. If an insured employer exercises the option and chooses a deductible, the insured employer shall be liable for the amount of the deductible for the medical <u>or indemnity</u> benefits paid for each claim of work injury suffered by an injured employee.

3. The Insurance Commissioner, in exercising the authority to approve the form of the policy to be issued, shall not approve any policy form that permits, directly or indirectly, any part of the deductible to be charged to or passed on to the injured worker or insurer.

4. The insurer shall pay the entire cost of medical bills directly to the provider of the services and then seek reimbursement from the insured employer for the deductible amount.

5. If the insured employer does not reimburse the deductible amount directly to the insurer within sixty (60) days of a written demand therefor, the insurer shall pay the compensable medical claim and may seek to recover the full amount of such claim from the insured employer.

6. Claim amounts up to Five Hundred Dollars ($500.00) annually which are paid under the medical or indemnity benefits deductible pursuant to this subsection shall be excluded from the calculation of the insured employer's experience modifier.

7. The provisions of this subsection shall be fully disclosed to the prospective purchaser in writing.

E. Every such policy issued to a sole proprietor, partnership, limited liability company, corporation, or other business entity must disclose to the potential purchaser in writing the option to elect to include the sole proprietors, any or all of the partnership members, any or all of the limited liability company members, or any or all stockholder-employees as employees for the purpose of workers' compensation insurance coverage by endorsing the policy in accordance with Section 3 of this title.

F. Every contract or agreement of an employer the purpose of which is to indemnify the employer from loss or damage on account of the injury of an employee by accidental means, or on account of the negligence of such employer or the employer's officer, agent or servant shall be absolutely void unless it shall also cover liability for the payment of the compensation provided for in this title.

G. No contract of insurance issued by a stock company or mutual association or other concern against the liability arising under this title shall be canceled within the time limited in such

contract for its expiration until at least ten (10) days after notice of intention to cancel such contract, on a date specified in such notice, shall be filed in the office of the Administrator and also served on the employer. Such notice shall be served on the employer by delivering it to the employer or by sending it by mail, by registered letter, addressed to the employer at the employer's last-known place of residence; provided, that if the employer be a partnership, then such notice may be so given to any one of the partners, and if the employer be a corporation, then the notice may be given to any agent or officer of the corporation upon whom legal process may be served. Provided, however, if a contract of insurance has been terminated by an employer insured thereunder who has obtained other compensation insurance, as evidenced by filing in compliance with Section 61 of this title, and no intervening rights of any employee are involved, omission of a predecessor insurer to file notice of time of termination of liability shall not constitute basis for imposition of liability against such predecessor insurer.

SECTION 25. REPEALER 36 O.S. 2001, Section 627, is hereby repealed.

SECTION 26. This act shall become effective November 1, 2005.

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