COMMITTEE AMENDMENT

HOUSE OF REPRESENTATIVES
State of Oklahoma

SPEAKER:

CHAIR:

I move to amend SB1022 Of the printed Bill

Page _____ Section _____ Lines _____ Of the Engrossed Bill

By striking the Title, the Enacting Clause, the entire bill, and by inserting in lieu thereof the following language:

AMEND TITLE TO CONFORM TO AMENDMENTS

Amendment submitted by: Daniel Sullivan

Adopted: _____

_____
Reading Clerk

STATE OF OKLAHOMA

1st Session of the 52nd Legislature (2009)

PROPOSED COMMITTEE
SUBSTITUTE
FOR ENGROSSED
SENATE BILL NO. 1022 By: Brown of the Senate

and

Sullivan of the House

PROPOSED COMMITTEE SUBSTITUTE

An Act relating to insurance; amending 36 O.S. 2001, Section 309.2, which relates to examination of insurance companies; expanding scope of examinations; requiring insurers to file certain statements with the Insurance Commissioner; specifying procedures and filing fee; providing effect of disclosures; specifying that such statements shall be treated as working papers and documents; authorizing the Insurance Commissioner to use such statements in making certain determinations; creating the Oklahoma Annual Financial Report Act; providing short title; stating purpose; specifying applicability of act; defining terms; requiring annual audit of financial reports; specifying procedures and contents of report; requiring insurers to register certain information with the Insurance Commissioner; providing procedures and requirements with regard to the registered information; providing exceptions and exemptions from certain requirements; providing procedures for obtaining an exception or exemption; specifying duties of accountants with regard to audited financial reports; providing for the treatment of workpapers of accountants auditing the financial statements of insurers; specifying scope of act as it applies to foreign and alien and certain other insurers; specifying duties and membership of audit committees of insurers; prohibiting directors

and officers of insurers from making certain statements or taking certain actions; requiring certain insurers to prepare and file an internal control over financing report; specifying contents of the report; providing for confidentiality; allowing Insurance Commissioner to grant exemptions from compliance with all or part of act; providing for implementation of act; amending 36 O.S. 2001, Section 361, as last amended by Section 2, Chapter 129, O.S.L. 2005 (36 O.S. Supp. 2008, Section 361), which relates to an Anti-Fraud Unit in the Insurance Department; modifying access to records of the Division; allowing certain insurers to be designated a domestic surplus line insurer; specifying requirements and restrictions; amending 36 O.S. 2001, Section 1219.4, as last amended by Section 9, Chapter 125, O.S.L. 2007 (36 O.S. Supp. 2008, Section 1219.4), which relates to discount medical plan organizations; adding requirements regarding nonrenewed registrations; authorizing the Insurance Commissioner to impose certain fines; amending 36 O.S. 2001, Sections 1435.6, as last amended by Section 44, Chapter 264, O.S.L. 2006, 1435.7, as last amended by Section 10, Chapter 184, O.S.L. 2008, 1435.8, as last amended by Section 45, Chapter 264, O.S.L. 2006, 1435.10, as amended by Section 46, Chapter 264, O.S.L. 2006, 1435.15, as last amended by Section 13, Chapter 125, O.S.L. 2007, 1435.23, as last amended by Section 13, Chapter 184, O.S.L. 2008, and 1435.29, as last amended by Section 14, Chapter 184, O.S.L. 2008 (36 O.S. Supp. 2008, Sections 1435.6, 1435.7, 1435.8, 1435.10, 1435.15, 1435.23 and 1435.29), which relate to the Oklahoma Producer Licensing Act; requiring applicants for a resident surplus lines broker to pass certain examination; deleting certain requirements; providing fee for certain changes in information; modifying penalties for failure to provide acceptable notification to the Insurance Commissioner of certain changes in information; modifying exemptions from required examinations; adding certain administrative fee; modifying certain continuing insurance education requirements; increasing hours for certain continuing education requirement; clarifying certain fee requirements; expanding exemption from certain fee requirement; deleting certain exemption from continuing insurance education requirements; amending

36 O.S. 2001, Section 3636, as amended by Section 25, Chapter 519, O.S.L. 2004 (36 O.S. Supp. 2008, Section 3636), which relates to uninsured motorist coverage; deleting obsolete language; amending 36 O.S. 2001, Section 4430, as amended by Section 31, Chapter 307, O.S.L. 2002 (36 O.S. Supp. 2008, Section 4430), which relates to the Long-Term Care Insurance Act; modifying limitation on increasing renewal rates; amending 36 O.S. 2001, Section 4509, which relates to group health insurance; modifying procedures for continuing coverage after certain occurrences; amending Section 2, Chapter 276, O.S.L. 2002 (36 O.S. Supp. 2008, Section 4522), which relates to the Employer Health Insurance Purchasing Group Act; modifying definitions; amending 36 O.S. 2001, Section 5002, as amended by Section 21, Chapter 184, O.S.L. 2008 (36 O.S. Supp. 2008, Section 5002), which relates to title insurers; deleting exemption from certain investment requirement; amending 36 O.S. 2001, Section 6055, as amended by Section 2, Chapter 288, O.S.L. 2003 (36 O.S. Supp. 2008, Section 6055), which relates to the Health Care Freedom of Choice Act; adding cost-sharing provision; amending 36 O.S. 2001, Sections 6103.2, 6103.3 and 6103.5, which relate to unauthorized insurance business; specifying scope of bail bond business; making certain remedies apply to unauthorized persons engaged in the bail bond business; expanding the authorization of the Insurance Commissioner to issue cease and desist orders; amending 36 O.S. 2001, Sections 6203, 6205, as amended by Section 24, Chapter 125, O.S.L. 2007, 6206, as amended by Section 25, Chapter 125, O.S.L. 2007, 6208, as amended by Section 26, Chapter 125, O.S.L. 2007, 6209, 6210, as last amended by Section 24, Chapter 184, O.S.L. 2008, 6212 and 6217, as last amended by Section 25, Chapter 184, O.S.L. 2008 (36 O.S. Supp. 2008, Sections 6205, 6206, 6208, 6210 and 6217), which relate to the Insurance Adjusters Licensing Act; modifying requirements for nonresident insurance adjusters; providing for an apprentice adjuster license; providing procedures and requirements for the license; limiting term of license; adding administrative fee for not providing changes to certain information to the Insurance Commissioner in a specified time frame; modifying certain fees; clarifying certain examination procedures; providing apprentice adjuster license

fee; adding administrative fee for submission of certain information after certain date; staggering term of adjustor licenses; modifying continuing insurance education requirements; amending Section 18, Chapter 334, O.S.L. 2004 (36 O.S. Supp. 2008, Section 6470.11), which relates to the Oklahoma Captive Insurance Company Act; modifying required use of accounting principals; amending 36 O.S. 2001, Section 6512, which relates to the Small Employer Health Insurance Reform Act; modifying definitions; amending 36 O.S. 2001, Sections 6602, as last amended by Section 17, Chapter 353, O.S.L. 2008, 6607, as amended by Section 20, Chapter 353, O.S.L. 2008 and 6608 (36 O.S. Supp. 2008, Sections 6602 and 6607), which relate to the Service Warranty Insurance Act; modifying definitions; modifying requirements for licensed associations; requiring the filing of financial statements and other information; amending Sections 11 and 12, Chapter 390, O.S.L. 2003 (36 O.S. Supp. 2008, Sections 6810 and 6811), which relate to the Medical Professional Liability Insurance Closed Claim Reports Act; adding short title; modifying definitions; adding procedures, requirements, and penalties for closed claim reporting; amending 59 O.S. 2001, Sections 1306, as last amended by Section 1, Chapter 135, O.S.L. 2006 and 1316, as last amended by Section 29, Chapter 184, O.S.L. 2008 (59 O.S. Supp. 2008, Sections 1306 and 1316), which relate to bail bondsmen; requiring the Insurance Commissioner to approve certain deposits; deleting certain authorization; repealing 36 O.S. 2001, Section 1425.5, which relates to the Oklahoma Producer Licensing Act; repealing 36 O.S. 2001, Section 6204, which relates to the Insurance Adjusters Licensing Act; repealing Section 13, Chapter 390, O.S.L. 2003, as amended by Section 71, Chapter 264, O.S.L. 2006 (36 O.S. Supp. 2008, Section 6812), which relates to medical professional liability insurance; 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 309.2, is amended to read as follows:

Section 309.2 A. The Insurance Commissioner or an examiner may conduct an examination, including a financial and market conduct examination, under Sections 309.1 through 309.7 of this title of any company as often as the Commissioner deems appropriate but shall at a minimum, conduct ~~an~~ a financial examination of every domestic insurer licensed in this state not less frequently than once every three (3) years. The Commissioner shall, at a minimum, conduct or cause to be conducted ~~an~~ a financial examination of every foreign insurer licensed in this state not less frequently than once every five (5) years. The Commissioner may accept examinations conducted by other states on foreign insurers domiciled in such states pursuant to subsection C of this section. In scheduling and determining the nature, scope and frequency of the examinations, the Commissioner shall consider such matters as the results of financial statement analyses and ratios, changes in management or ownership, actuarial opinions, reports of independent certified financial examiners or public accountants and other criteria as set forth in the Examiners' Handbook adopted by the National Association of Insurance Commissioners and in effect when the Commissioner exercises discretion under this subsection. The Commissioner may also make examinations upon the request of one or more persons pecuniarily interested therein, who shall make affidavit of their

belief, with specifications of their reasons therefor, that the company is in an unsound condition.

B. For purposes of completing an examination of any company under Sections 309.1 through 309.7 of this title, the Commissioner may examine or investigate any person, or the business of any person, insofar as such examination or investigation is, in the sole discretion of the Commissioner, necessary or material to the examination of the company.

C. In lieu of an examination under Sections 309.1 through 309.7 of this title of any foreign or alien insurer licensed in this state, the Commissioner may accept an examination report on such company as prepared by the insurance department for the company's state of domicile or port-of-entry state if:

1. The insurance department was at the time of the examination accredited under the National Association of Insurance Commissioners' Financial Regulation Standards and Accreditation Program; or

2. The examination is performed with the participation of one or more examiners who are employed by an accredited state insurance department and who, after a review of the examination work papers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by their insurance department.

D. The Commissioner may authorize any employee of the Insurance Department to exercise the Commissioner's authority under Sections 309.1 through 309.7 of this title.

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 311.4 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Insurers authorized to do business under the provisions of the Oklahoma Insurance Code shall, annually, on or before the last day of June, file with the Insurance Commissioner market conduct annual statements reporting market conduct data of insurers on the thirty-first day of December of the previous year. The statements shall report on the lines of insurance and be in such general form and context as approved by the National Association of Insurance Commissioners, and as supplemented for additional information required by the Insurance Commissioner by rule. The statements shall be prepared in accordance with NAIC instructions, including any supplemental filings described in the NAIC instructions. If no forms or instructions are available from the National Association of Insurance Commissioners, the statements shall be in the form and pursuant to instructions as provided by the Insurance Commissioner. Insurers not authorized by the Insurance Commissioner to provide the lines of insurance approved by the National Association or the Insurance Commissioner shall not be required to file market conduct annual statements. For good cause shown, the Insurance Commissioner

may extend the time within which market conduct annual statements may be filed. The Insurance Commissioner may provide copies of market conduct annual statements, amendments, and addendums to such statements and market conduct data taken from such statements to the National Association of Insurance Commissioners.

B. The Insurance Commissioner may adopt rules implementing this section including rules that:

1. Add lines of insurance to be reported in market conduct annual statements; and

2. Require the filing of market conduct annual statements and any amendments and addendums to such statements with the National Association of Insurance Commissioners, and the payment of applicable filing fees required by the NAIC.

C. Insurers shall pay a filing fee of Two Hundred Dollars ($200.00) to the Insurance Commissioner for the filing of the market conduct annual statement.

D. No waiver of an applicable privilege or claim of confidentiality in the documents, materials, or other information shall occur as a result of disclosure to the Insurance Commissioner or the Commissioner’s designee under this section or as a result of sharing the documents, materials or other information as provided in this section.

E. Market conduct annual statements and any amendments and addendums to such statements, filed with the Insurance Commissioner

pursuant to this section in electronic format or otherwise, shall be treated as working papers and documents as set out in subsection F of Section 309.4 of Title 36 of the Oklahoma Statutes.

F. The Insurance Commissioner may use market conduct annual statements or amendments or addendums to such statements to assist in determining whether a market conduct examination or investigation of an insurer should be conducted. For purposes of completing a market conduct examination of any company under Sections 309.1 through 309.7 of Title 36 of the Oklahoma Statutes, the Insurance Commissioner may, in the sole discretion of the Insurance Commissioner, use market conduct annual statements or amendments or addendums to such statements to assist in determining compliance with the laws of this state and rules adopted by the Insurance Commissioner.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 311A.1 of Title 36, unless there is created a duplication in numbering, reads as follows:

Sections 3 through 20 of this act shall be known as and may be cited as the "Oklahoma Annual Financial Report Act".

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 311A.2 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The purpose of the Oklahoma Annual Financial Report Act is to improve the surveillance of the Insurance Commissioner over the financial condition of insurers by requiring:

1. An annual audit of financial statements reporting the financial position and the results of operations of insurers by independent certified public accountants;

2. Communication of Internal Control Related Matters Noted in an Audit; and

3. Management's Report of Internal Control over Financial Reporting.

B. Every insurer as defined in Section 5 of this act shall be subject to the Oklahoma Annual Financial Report Act. Insurers having direct premiums written in this state of less than One Million Dollars ($1,000,000.00) in any calendar year and less than one thousand policy holders or certificate holders of direct written policies nationwide at the end of the calendar year shall be exempt from the Oklahoma Annual Financial Report Act for the year unless the Commissioner makes a specific finding that compliance is necessary for the Commissioner to carry out statutory responsibilities. Insurers having assumed premiums pursuant to contracts and treaties of reinsurance of One Million Dollars ($1,000,000.00) or more will not be so exempt.

C. Foreign or alien insurers filing the audited financial reports in another state, pursuant to the requirement of that state

for filing of audited financial reports, which has been found by the Commissioner to be substantially similar to the requirements of the Oklahoma Annual Financial Report Act, are exempt from Sections 6 through 15 of this act if:

1. A copy of the audited financial report, Communication of Internal Control Related Matters Noted in an Audit, and the Accountant's Letter of Qualifications that are filed with the other state are filed with the Commissioner in accordance with the filing dates specified in Sections 6, 13 and 14 of this act, respectively. Canadian insurers may submit accountants' reports as filed with the Office of the Superintendent of Financial Institutions, Canada; and

2. A copy of any Notification of Adverse Financial Condition Report filed with the other state is filed with the Commissioner within the time specified in Section 12 of this act.

D. Foreign or alien insurers required to file Management's Report of Internal Control over Financial Reporting in another state are exempt from filing the Report in this state provided the other state has substantially similar reporting requirements as determined by the Commissioner and the Report is filed with the Commissioner of the other state within the time specified.

E. The Oklahoma Annual Financial Report Act shall not prohibit, preclude, or in any way limit the Commissioner from ordering or conducting or performing examinations of insurers under the rules of

the Insurance Department and the practices and procedures of the Insurance Department.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 311A.3 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. As used in the Oklahoma Annual Financial Report Act:

1. "Accountant" or "independent certified public accountant" means an independent certified public accountant or accounting firm in good standing with the American Institute of Certified Public Accounts (AICPA) and in all states in which the accountant is licensed to practice and for Canadian and British companies, it means a Canadian-chartered or British-chartered accountant;

2. An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified;

3. "Audit committee" means a committee or equivalent body established by the board of directors of an entity for the purpose of overseeing the accounting and financial reporting processes of an insurer or group of insurers, and audits of financial statements of the insurer or group of insurers, and audits of financial statements of the insurer or group of insurers. The audit committee of any entity that controls a group of insurers may be deemed to be the audit committee for one or more of these controlled insurers solely

for the purposes of the Oklahoma Annual Financial Report Act at the election of the controlling person. The exercise of this election shall be pursuant to subsection E of Section 16 of this act. If an audit committee is not designated by the insurer, the entire board of directors of the insurer shall constitute the audit committee;

4. "Audited financial report" means and includes those items specified in Section 7 of this act;

5. "Indemnification" means an agreement of indemnity or a release from liability where the intent or effect is to shift or limit in any manner the potential liability of the person or firm for failure to adhere to applicable auditing or professional standards, whether or not resulting in part from knowing of other misrepresentations made by the insurer or its representatives;

6. "Independent board member" has the same meaning as described in subsection C of Section 16 of this act;

7. "Insurer" means a licensed insurer as defined in Section 103 of Title 36 of the Oklahoma Statutes. For purposes of the Oklahoma Annual Financial Report Act, insurer includes but is not limited to fraternal benefit societies, health maintenance organizations, multiple employer welfare arrangements, title insurers, and similar organizations licensed by the Insurance Commissioner;

8. "Group of insurers" means those licensed insurers included in the reporting requirements of Article 16A of the Oklahoma Insurance Code, or a set of insurers as identified by management,

for the purpose of assessing the effectiveness of internal control over financial reporting;

9. "Internal control over financial reporting" means a process effected by the board of directors, management, and other personnel of an entity designed to provide reasonable assurance regarding the reliability of the financial statements, i.e., those items specified in paragraphs 2 through 7 of subsection B of Section 7 of this act and includes those policies and procedures that:

a. pertain to the maintenance of records that, in reasonable detail and accurately, fairly reflect the transactions and dispositions of assets,

b. provide reasonable assurance that transactions are recorded as necessary to permit preparation of the financial statements, i.e., those items specified in paragraphs 2 through 7 of subsection B of Section 7 of this act and that receipts and expenditures are being made only in accordance with authorizations of management and directors, and

c. provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of assets that could have a material effect on the financial statements, i.e., those items specified in paragraphs 2 through 7 of subsection B of Section 7 of this act;

10. "SEC" means the United States Securities and Exchange Commission;

11. "Section 404" means Section 404 of the Sarbanes-Oxley Act of 2002 and the rules and regulations of the SEC promulgated thereunder;

12. "Section 404 Report" means the report on internal control over financial reporting of management as defined by the SEC and the related attestation report of the independent certified public accountant; and

13. "SOX Compliant Entity" means an entity that either is required to be compliant with, or voluntarily is compliant with, all of the following provisions of the Sarbanes-Oxley Act of 2002:

a. the preapproval requirements of Section 201 (Section 10A(i) of the Securities Exchange Act of 1934),

b. the audit committee independence requirements of Section 301 (Section 10A(m)(3) of the Securities Exchange Act of 1934), and

c. the internal control over financial reporting requirements of Section 404 (Item 308 of SEC Regulation S-K).

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 311A.4 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. All insurers shall have an annual audit by an independent certified public accountant and shall file an audited financial report with the Insurance Commissioner on or before June 1 for the year ended December 31 immediately preceding. The Commissioner may require an insurer to file an audited financial report earlier than June 1 with ninety (90) days advance notice to the insurer.

B. Extensions of the June 1 filing date may be granted by the Commissioner for thirty-day periods upon a showing by the insurer and its independent certified public accountant of the reasons for requesting an extension and determination by the Commissioner of good cause for an extension. The request for extension must be submitted in writing not less than ten (10) days prior to the due date in sufficient detail to permit the Commissioner to make an informed decision with respect to the requested extension.

C. If an extension is granted in accordance with the provisions in subsection B of this section, a similar extension of thirty (30) days is granted to the filing of Management's Report of Internal Control over Financial Reporting.

D. Every insurer required to file an annual audited financial report pursuant to the Oklahoma Annual Financial Report Act shall designate a group of individuals as constituting its audit committee. The audit committee of an entity that controls an insurer may be deemed to be the audit committee of the insurer for

purposes of the Oklahoma Annual Financial Report Act at the election of the controlling person.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 311A.5 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The annual audited financial report shall report the financial position of the insurer as of the end of the most recent calendar year and the results of its operations, cash flows, and changes in capital and surplus for the year then ended in conformity with statutory accounting practices prescribed, or otherwise permitted, by the Department of Insurance of the state of domicile.

B. The annual audited financial report shall include the following:

1. Report of independent certified public accountant;

2. Balance sheet reporting admitted assets, liabilities, capital, and surplus;

3. Statement of operations;

4. Statement of cash flows;

5. Statement of changes in capital and surplus;

6. Notes to financial statements. These notes shall be those required by the appropriate NAIC Annual Statement Instructions and the NAIC Accounting Practices and Procedures Manual. The notes shall include a reconciliation of differences, if any, between the audited statutory financial statements and the annual statement

filed pursuant to Section 311 of Title 36 of the Oklahoma Statutes with a written description of the nature of these differences; and

7. The financial statements included in the audited financial report shall be prepared in a form and using language and groupings substantially the same as the relevant sections of the annual statement of the insurer filed with the Commissioner, and the financial statement shall be comparative, presenting the amounts as of December 31 of the current year and the amounts as of the immediately preceding December 31. However, in the first year in which an insurer is required to file an audited financial report, the comparative data may be omitted.

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 311A.6 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Each insurer required by the Oklahoma Annual Financial Report Act to file an annual audited financial report must within sixty (60) days after becoming subject to the requirement, register with the Insurance Commissioner in writing the name and address of the independent certified public accountant or accounting firm retained to conduct the annual audit set forth in the Oklahoma Annual Financial Report Act. Insurers not retaining an independent certified public accountant on the effective date of the Oklahoma Annual Financial Report Act shall register the name and address of their retained independent certified public accountant not less than

six (6) months before the date when the first audited financial report is to be filed.

B. The insurer shall obtain a letter from the accountant, and file a copy with the Commissioner stating that the accountant is aware of the provisions of the insurance code and the regulations of the insurance department of the state of domicile that relate to accounting and financial matters and affirming that the accountant will express the opinion of the accountant on the financial statements in terms of their conformity to the statutory accounting practices prescribed or otherwise permitted by that insurance department, specifying such exceptions as the accountant may believe appropriate.

C. If an accountant who was the accountant for the immediately preceding filed audited financial report is dismissed or resigns, the insurer shall within five (5) business days notify the Commissioner of this event. The insurer shall also furnish the Commissioner with a separate letter within ten (10) business days of the above notification stating whether in the twenty-four (24) months preceding such event there were any disagreements with the former accountant on any matter of accounting principles or practices, financial statement disclosure, or auditing scope or procedure, which disagreements, if not resolved to the satisfaction of the former accountant, would have caused the former accountant to make reference to the subject matter of the disagreement in

connection with the opinion of the former accountant. The disagreements required to be reported in response to this section include both those resolved to the satisfaction of the former accountant and those not resolved to the satisfaction of the former accountant. Disagreements contemplated by this section are those that occur at the decision-making level, between personnel of the insurer responsible for presentation of its financial statements and personnel of the accounting firm responsible for rendering its report. The insurer shall also in writing request the former accountant to furnish a letter addressed to the insurer stating whether the accountant agrees with the statements contained in the letter of the insurer and, if not, stating the reasons for which the accountant does not agree. The insurer shall furnish the responsive letter from the former accountant to the Commissioner together with its own.

SECTION 9. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 311A.7 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The Insurance Commissioner shall not recognize a person or firm as a qualified independent certified public accountant if the person or firm:

1. Is not in good standing with the AICPA and in all states in which the accountant is licensed to practice, or, for a Canadian or British company, that is not a chartered accountant; or

2. Has either directly or indirectly entered into an agreement of indemnity or release from liability, collectively referred to as indemnification, with respect to the audit of the insurer.

B. Except as otherwise provided in the Oklahoma Annual Financial Report Act, the Commissioner shall recognize an independent certified public accountant as qualified as long as the accountant conforms to the standards of the profession, as contained in the Code of Professional Ethics of the AICPA and Rules and Regulations and Code of Ethics and Rules of Professional Conduct of the Oklahoma Board of Public Accountancy, or similar code.

C. A qualified independent certified public accountant may enter into an agreement with an insurer to have disputes relating to an audit resolved by mediation or arbitration. However, in the event of a delinquency proceeding commenced against the insurer under Article 19 of the Oklahoma Insurance Code, the mediation or arbitration provisions shall operate at the option of the statutory successor.

D. 1. The lead or coordinating audit partner having primary responsibility for the audit may not act in that capacity for more than five (5) consecutive years. The person shall be disqualified from acting in that or a similar capacity for the same company or its insurance subsidiaries or affiliates for a period of five (5) consecutive years. An insurer may make application to the Commissioner for relief from the above rotation requirement on the

basis of unusual circumstances. This application should be made at least thirty (30) days before the end of the calendar year. The Commissioner may consider the following factors in determining if the relief should be granted:

a. number of partners, expertise of the partners, or the number of insurance clients in the currently registered firm,

b. premium volume of the insurer, or

c. number of jurisdictions in which the insurer transacts business.

2. The insurer shall file, with its annual statement filing, the approval for relief from paragraph 1 of this subsection with the states that it is licensed in or doing business in and with the NAIC. If the nondomestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC.

E. The Commissioner shall neither recognize as a qualified independent certified public accountant, nor accept an annual audited financial report, prepared in whole or in part by, a natural person who:

1. Has been convicted of fraud, bribery, a violation of the Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. Sections 1961 to 1968, or any dishonest conduct or practices under federal or state law;

2. Has been found to have violated the insurance laws of this state with respect to any previous reports submitted under the Oklahoma Annual Financial Report Act; or

3. Has demonstrated a pattern or practice of failing to detect or disclose material information in previous reports filed under the provisions of the Oklahoma Annual Financial Report Act.

F. The Commissioner may hold a hearing to determine whether an independent certified public accountant is qualified and, considering the evidence presented, may rule that the accountant is not qualified for purposes of expressing the opinion of the accountant on the financial statements in the annual audited financial report made pursuant to the Oklahoma Annual Financial Report Act and require the insurer to replace the accountant with another whose relationship with the insurer is qualified within the meaning of the Oklahoma Annual Financial Report Act.

G. 1. The Commissioner shall not recognize as a qualified independent certified public accountant, nor accept an annual audited financial report, prepared in whole or in part by an accountant who provides to an insurer, contemporaneously with the audit, the following non-audit services:

a. bookkeeping or other services related to the accounting records or financial statements of the insurer,

b. financial information systems design and implementation,

c. appraisal or valuation services, fairness opinions, or contribution-in-kind reports,

d. actuarially oriented advisory services involving the determination of amounts recorded in the financial statements. The accountant may assist an insurer in understanding the methods, assumptions, and inputs used in the determination of amounts recorded in the financial statement only if it is reasonable to conclude that the services provided will not be subject to audit procedures during an audit of the financial statements of the insurer. The actuary of an accountant may also issue an actuarial opinion or certification on the reserves of an insurer if the following conditions have been met:

(1) neither the accountant nor the actuary of the accountant has performed any management functions or made any management decisions,

(2) the insurer has competent personnel or engages a third-party actuary to estimate the reserves for which management takes responsibility, and

(3) the actuary of the accountant tests the reasonableness of the reserves after the

management of the insurer has determined the amount of the reserves,

e. internal audit outsourcing services,

f. management functions or human resources,

g. broker or dealer, investment adviser, or investment banking services,

h. legal services or expert services unrelated to the audit, or

i. any other services that the Commissioner determines, by rule, are impermissible.

2. In general, the principles of independence with respect to services provided by the qualified independent certified public accountant are largely predicated on three basic principles, violations of which would impair the independence of the accountant. The principles are that the accountant cannot function in the role of management, cannot audit the own work of the accountant, and cannot serve in an advocacy role for the insurer.

H. Insurers having direct written and assumed premiums of less than One Hundred Million Dollars ($100,000,000.00) in any calendar year may request an exemption from paragraph 1 of subsection G of this section. The insurer shall file with the Commissioner a written statement discussing the reasons why the insurer should be exempt from these provisions. If the Commissioner finds, upon review of the statement, that compliance with the Oklahoma Annual

Financial Report Act would constitute a financial or organizational hardship upon the insurer, an exemption may be granted.

I. A qualified independent certified public accountant who performs the audit may engage in other non-audit services, including tax services, that are not described in paragraph 1 of subsection G of this section or that do not conflict with paragraph 2 of subsection G of this section, only if the activity is approved in advance by the audit committee, in accordance with subsection J of this section.

J. All auditing services and non-audit services provided to an insurer by the qualified independent certified public accountant of the insurer shall be preapproved by the audit committee. The preapproval requirement is waived with respect to non-audit services if the insurer is a SOX Compliant Entity or a direct or indirect wholly-owned subsidiary of a SOX Compliant entity or:

1. The aggregate amount of all such non-audit services provided to the insurer constitutes not more than five percent (5%) of the total amount of fees paid by the insurer to its qualified independent certified public accountant during the fiscal year in which the non-audit services are provided;

2. The services were not recognized by the insurer at the time of the engagement to be non-audit services; and

3. The services are promptly brought to the attention of the audit committee and approved prior to the completion of the audit by

the audit committee or by one or more members of the audit committee who are the members of the board of directors to whom authority to grant such approvals has been delegated by the audit committee.

K. The audit committee may delegate to one or more designated members of the audit committee the authority to grant the preapprovals required by subsection J of this section. The decisions of any member to whom this authority is delegated shall be presented to the full audit committee at each of its scheduled meetings.

L. 1. The Commissioner shall not recognize an independent certified public accountant as qualified for a particular insurer if a member of the board, president, chief executive officer, controller, chief financial officer, chief accounting officer, or any person serving in an equivalent position for that insurer, was employed by the independent certified public accountant and participated in the audit of that insurer during the one-year period preceding the date that the most current statutory opinion is due. This subsection shall only apply to partners and senior managers involved in the audit. An insurer may make application to the Commissioner for relief from the above requirement on the basis of unusual circumstances.

2. The insurer shall file, with its annual statement filing, the approval for relief from paragraph 1 of this subsection with the states that it is licensed in or doing business in and the NAIC. If

the nondomestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC.

SECTION 10. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 311A.8 of Title 36, unless there is created a duplication in numbering, reads as follows:

An insurer may make written application to the Insurance Commissioner for approval to file audited consolidated or combined financial statements in lieu of separate annual audited financial statements if the insurer is part of a group of insurance companies that utilizes a pooling or one hundred percent (100%) reinsurance agreement that affects the solvency and integrity of the reserves of the insurer and the insurer cedes all of its direct and assumed business to the pool. In such cases, a columnar consolidating or combining worksheet shall be filed with the report, as follows:

1. Amounts shown on the consolidated or combined audited financial report shall be shown on the worksheet;

2. Amounts for each insurer subject to this section shall be stated separately;

3. Noninsurance operations may be shown on the worksheet on a combined or individual basis;

4. Explanations of consolidating and eliminating entries shall be included; and

5. A reconciliation shall be included of any differences between the amounts shown in the individual insurer columns of the worksheet and comparable amounts shown on the annual statements of the insurers.

SECTION 11. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 311A.9 of Title 36, unless there is created a duplication in numbering, reads as follows:

Financial statements furnished pursuant to Section 7 of this act shall be examined by the independent certified public accountant. The audit of the financial statements of the insurer shall be conducted in accordance with generally accepted auditing standards. In accordance with AU Section 319 of the Professional Standards of the AICPA, Consideration of Internal Control in a Financial Statement Audit, the independent certified public accountant should obtain an understanding of internal control sufficient to plan the audit. To the extent required by AU 319, for those insurers required to file a Management's Report of Internal Control over Financial Reporting pursuant to Section 18 of this act, the independent certified public accountant should consider, as that term is defined in Statement on Auditing Standards (SAS) No. 102, Defining Professional Requirements in Statements on Auditing Standards or its replacement, the most recently available report in planning and performing the audit of the statutory financial statements. Consideration shall be given to the procedures

illustrated in the Financial Condition Examiners Handbook promulgated by the National Association of Insurance Commissioners as the independent certified public accountant deems necessary.

SECTION 12. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 311A.10 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The insurer required to furnish the annual audited financial report shall require the independent certified public accountant to report, in writing, within five (5) business days to the board of directors or its audit committee any determination by the independent certified public accountant that the insurer has materially misstated its financial condition as reported to the Insurance Commissioner as of the balance sheet date currently under audit or that the insurer does not meet the minimum capital and surplus requirement of the Oklahoma Insurance Code as of that date. An insurer that has received a report pursuant to this subsection shall forward a copy of the report to the Commissioner within five (5) business days of receipt of the report and shall provide the independent certified public accountant making the report with evidence of the report being furnished to the Commissioner. If the independent certified public accountant fails to receive the evidence within the required five (5) business day period, the independent certified public accountant shall furnish to the

Commissioner a copy of its report within the next five (5) business days.

B. No independent certified public accountant shall be liable in any manner to any person for any statement made in connection with subsection A of this section if the statement is made in good faith in compliance with that subsection.

C. If the accountant, subsequent to the date of the audited financial report filed pursuant to the Oklahoma Annual Financial Report Act, becomes aware of facts that might have affected the report of the accountant, the accountant shall comply with the action or actions prescribed in Volume 1, Section AU 561 of the Professional Standards of the AICPA.

SECTION 13. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 311A.11 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. In addition to the annual audited financial report, each insurer shall furnish the Insurance Commissioner with a written communication as to any unremediated material weaknesses in its internal controls over financial reporting noted during the audit. Such communication shall be prepared by the accountant within sixty (60) days after the filing of the annual audited financial report, and shall contain a description of any unremediated material weakness, as the term material weakness is defined by Statement on Auditing Standard 60, Communication of Internal Control Related

Matters Noted in an Audit, or its replacement, as of December 31 immediately preceding, so as to coincide with the audited financial report discussed in subsection A of Section 4 of this act in the internal control over financial reporting of the insurer noted by the accountant during the course of their audit of the financial statements. If no unremediated material weaknesses were noted, the communication should so state.

B. The insurer is required to provide a description of remedial actions taken or proposed to correct unremediated material weaknesses if the actions are not described in the communication of the accountant.

SECTION 14. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 311A.12 of Title 36, unless there is created a duplication in numbering, reads as follows:

The accountant shall furnish the insurer in connection with, and for inclusion in, the filing of the annual audited financial report, a letter stating:

1. That the accountant is independent with respect to the insurer and conforms to the standards of the profession as contained in the Code of Professional Ethics and pronouncements of the AICPA and the Rules of Professional Conduct of the Oklahoma Board of Public Accountancy, or similar code;

2. The background and experience in general, and the experience in audits of insurers of the staff assigned to the engagement and

whether each is an independent certified public accountant. Nothing within the Oklahoma Annual Financial Report Act shall be construed as prohibiting the accountant from utilizing such staff as the accountant deems appropriate where use is consistent with the standards prescribed by generally accepted auditing standards;

3. That the accountant understands the annual audited financial report and the opinion of the accountant thereon will be filed in compliance with the Oklahoma Annual Financial Report Act and that the Insurance Commissioner will be relying on this information in the monitoring and regulation of the financial position of insurers;

4. That the accountant consents to the requirements of section 15 of this act and that the accountant consents and agrees to make available for review by the Commissioner the workpapers, as defined in Section 15 of this act;

5. A representation that the accountant is properly licensed by an appropriate state licensing authority and is a member in good standing in the AICPA; and

6. A representation that the accountant is in compliance with the requirements of Section 9 of this act.

SECTION 15. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 311A.13 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Workpapers are the records kept by the independent certified public accountant of the procedures followed, the tests performed,

the information obtained, and the conclusions reached pertinent to the audit by the accountant of the financial statements of an insurer. Workpapers, accordingly, may include audit planning documentation, work programs, analyses, memoranda, letters of confirmation and representation, abstracts of company documents, and schedules or commentaries prepared or obtained by the independent certified public accountant in the course of the audit of the financial statements of an insurer and which support the opinion of the accountant.

B. Every insurer required to file an audited financial report pursuant to the Oklahoma Annual Financial Report Act, shall require the accountant to make available for review by Insurance Department examiners, all workpapers prepared in the conduct of the audit by the accountant and any communications related to the audit between the accountant and the insurer, at the offices of the insurer, at the offices of the Insurance Department, or at any other reasonable place designated by the Insurance Commissioner. The insurer shall require that the accountant retain the audit workpapers and communications until the Insurance Department has filed a report on examination covering the period of the audit but no longer than seven (7) years from the date of the audit report.

C. In the conduct of the aforementioned periodic review by the Insurance Department examiners, it shall be agreed that photocopies of pertinent audit workpapers may be made and retained by the

Insurance Department. Such reviews by the Insurance Department examiners shall be considered investigations and all working papers and communications obtained during the course of such investigations shall be afforded the same confidentiality as other examination workpapers generated by the Insurance Department pursuant to subsection F of Section 309.4 of Title 36 of the Oklahoma Statutes.

SECTION 16. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 311A.14 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. This section shall not apply to foreign or alien insurers licensed in this state or an insurer that is a SOX Compliant Entity or a direct or indirect wholly-owned subsidiary of a SOX Compliant Entity.

B. The audit committee shall be directly responsible for the appointment, compensation, and oversight of the work of any accountant, including resolution of disagreements between management and the accountant regarding financial reporting, for the purpose of preparing or issuing the audited financial report or related work pursuant to the Oklahoma Annual Financial Report Act. Each accountant shall report directly to the audit committee.

C. Each member of the audit committee shall be a member of the board of directors of the insurer or a member of the board of directors of an entity elected pursuant to subsection F of this section and paragraph 3 of Section 5 of this act.

D. In order to be considered independent for purposes of this section, a member of the audit committee may not, other than in the capacity as a member of the audit committee, the board of directors, or any other board committee, accept any consulting, advisory, or other compensatory fee from the entity or be an affiliated person of the entity or subsidiary thereof. However, if law requires board participation by otherwise non-independent members, that law shall prevail and such members may participate in the audit committee and be designated as independent for audit committee purposes, unless they are an officer or employee of the insurer or one of its affiliates.

E. If a member of the audit committee ceases to be independent for reasons outside the reasonable control of the member, that person, with notice by the responsible entity to the state, may remain an audit committee member of the responsible entity until the earlier of the next annual meeting of the responsible entity or one year from the occurrence of the event that caused the member to be no longer independent.

F. To exercise the election of the controlling person to designate the audit committee for purposes of the Oklahoma Annual Finance Report Act, the ultimate controlling person shall provide written notice to the Insurance Commissioner of the affected insurers. Notification shall be made timely prior to the issuance of the statutory audit report and include a description of the basis

for the election. The election can be changed through notice to the Commissioner by the insurer, which shall include a description of the basis for the change. The election shall remain in effect for perpetuity, until rescinded.

G. 1. The audit committee shall require the accountant that performs for an insurer any audit required by the Oklahoma Annual Financial Report Act to timely report to the audit committee in accordance with the requirements of SAS 61, Communication with Audit Committees, or its replacement, including:

a. all significant accounting policies and material permitted practices,

b. all material alternative treatments of financial information within statutory accounting principles that have been discussed with management officials of the insurer, ramifications of the use of the alternative disclosures and treatments, and the treatment preferred by the accountant, and

c. other material written communications between the accountant and the management of the insurer, such as any management or schedule of unadjusted differences;

2. If an insurer is a member of an insurance holding company system, the reports required by paragraph 1 of this subsection may be provided to the audit committee on an aggregate basis for insurers in the holding company system, provided that any

substantial differences among insurers in the system are identified to the audit committee.

H. The proportion of independent audit committee members shall meet or exceed the following criteria set out in paragraphs 1, 2 and 3 of this subsection:

1. No Minimum Requirements. There are no minimum requirements for insurers with prior calendar year direct written and assumed premiums of Three Hundred Million Dollars ($300,000,000.00) or less;

2. Majority of Members. Fifty percent (50%) or more of members of the independent audit committee for insurers with prior calendar year direct written and assumed premiums of between Three Hundred Million Dollars ($300,000,000.00) and Five Hundred Million Dollars ($500,000,000.00);

3. Supermajority of Members. Seventy-five percent (75%) or more of members of the independent audit committee for insurers with prior calendar year direct written and assumed premiums of over Five Hundred Million Dollars ($500,000,000.00).

I. The Commissioner may require improvements to the independence of the audit committee membership of any insurer if the insurer is in a RBC action level event, meets one or more of the standards of an insurer deemed to be in hazardous financial condition, or otherwise exhibits qualities of a troubled insurer.

J. For purposes of this section, prior calendar year direct written and assumed premiums shall be the combined total of direct

premiums and assumed premiums from non-affiliates for the reporting entities.

K. An insurer with direct written and assumed premium, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, of less than Five Hundred Million Dollars ($500,000,000.00) may make application to the Commissioner for a waiver from the requirements of this section based upon hardship. The insurer shall file, with its annual statement filing, the approval for relief from this section with the states that it is licensed in or doing business in and the NAIC. If the nondomestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC.

SECTION 17. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 311A.15 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. No director or officer of an insurer shall, directly or indirectly:

1. Make or cause to be made a materially false or misleading statement to an accountant in connection with any audit, review, or communication required under the Oklahoma Annual Financial Report Act; or

2. Omit to state, or cause another person to omit to state, any material fact necessary in order to make statements made, in light

of the circumstances under which the statements were made, not misleading to an accountant in connection with any audit, review, or communication required under the Oklahoma Annual Financial Report Act.

B. No officer or director of an insurer, or any other person acting under the direction thereof, shall directly or indirectly take any action to coerce, manipulate, mislead, or fraudulently influence any accountant engaged in the performance of an audit pursuant to the Oklahoma Annual Financial Report Act if that person knew or should have known that the action, if successful, could result in rendering the financial statements of the insurer materially misleading.

C. For purposes of subsection B of this section, actions that, if successful, could result in rendering the financial statements of the insurer materially misleading include, but are not limited to, actions taken at any time with respect to the professional engagement period to coerce, manipulate, mislead, or fraudulently influence an accountant:

1. To issue or reissue a report on the financial statements of an insurer that is not warranted in the circumstances due to material violations of statutory accounting principles prescribed by the Insurance Commissioner, generally accepted auditing standards, or other professional or regulatory standards;

2. Not to perform audit, review or other procedures required by generally accepted auditing standards or other professional standards;

3. Not to withdraw an issued report; or

4. Not to communicate matters to the audit committee of an insurer.

SECTION 18. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 311A.16 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Every insurer required to file an audited financial report pursuant to the Oklahoma Annual Financial Report Act that has annual direct written and assumed premiums, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, of Five Hundred Million Dollars ($500,000,000.00) or more shall prepare a report of the insurer's or group of insurers' internal control over financial reporting. The report shall be filed with the Insurance Commissioner along with the Communication of Internal Control Related Matters Noted in an Audit described under Section 13 of this act. Management's Report of Internal Control over Financial Reporting shall be as of December 31 immediately preceding.

B. Notwithstanding the premium threshold in subsection A of this section, the Commissioner may require an insurer to file Management's Report of Internal Control over Financial Reporting if

the insurer is in any RBC level event, or meets any one or more of the standards of an insurer deemed to be in hazardous financial condition.

C. An insurer or a group of insurers that is:

1. Directly subject to Section 404;

2. Part of a holding company system whose parent is directly subject to Section 404;

3. Not directly subject to Section 404 but is a SOX compliant Entity; or

4. A member of a holding company system whose parent is not directly subject to Section 404 but is a SOX Compliant Entity, may file its or its parent's Section 404 Report and an addendum in satisfaction of the requirements of this section provided that those internal controls of the insurer or group of insurers' audited statutory financial statements included in paragraphs 2 through 7 of subsection B of Section 7 of this act were included in the scope of the Section 404 Report. The addendum shall be a positive statement by management that there are no material processes with respect to the preparation of the insurer's or group of insurers' audited statutory financial statements included in paragraphs 2 through 7 of subsection B of Section 7 of this act excluded from the Section 404 Report. If there are internal controls of the insurer or group of insurers that have a material impact on the preparation of the insurer's or group of insurer's audited statutory financial

statements and those internal controls were not included in the scope of the Section 404 Report, the insurer or group of insurers may either file a report pursuant to this section or the Section 404 Report and a report pursuant to this section for those internal controls that have a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements not covered by the Section 404 Report.

D. Management's Report of Internal Control over Financial Reporting shall include:

1. A statement that management is responsible for establishing and maintaining adequate internal control over financial reporting;

2. A statement that management has established internal control over financial reporting and an assertion, to the best of the knowledge and belief of management, after diligent inquiry, as to whether its internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles;

3. A statement that briefly describes the approach or processes by which management evaluated the effectiveness of its internal control over financial reporting;

4. A statement that briefly describes the scope of work that is included and whether any internal controls were excluded;

5. Disclosure of any unremediated material weaknesses in the internal control over financial reporting identified by management as of December 31 immediately preceding. Management is not permitted to conclude that the internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles if there is one or more unremediated material weaknesses in its internal control over financial reporting;

6. A statement regarding the inherent limitations of internal control systems; and

7. Signatures of the chief executive officer and the chief financial officer or equivalent positions or titles.

E. Management shall document and make available upon financial condition examination the basis upon which its assertions, required in subsection D of this section, are made. Management may base its assertions, in part, upon its review, monitoring, and testing of internal controls undertaken in the normal course of its activities.

1. Management shall have discretion as to the nature of the internal control framework used, and the nature and extent of documentation, in order to make its assertion in a cost effective manner and, as such, may include assembly of or reference to existing documentation.

2. Management's Report of Internal Control over Financial Reporting, required by subsection A of this section and any

documentation provided in support thereof during the course of a financial condition examination, shall be kept confidential by the Insurance Department.

SECTION 19. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 311A.17 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Upon written application of any insurer, the Insurance Commissioner may grant an exemption from compliance with any and all provisions of the Oklahoma Annual Financial Report Act if the Commissioner finds, upon review of the application, that compliance with the Oklahoma Annual Financial Report Act would constitute a financial or organizational hardship upon the insurer. An exemption may be granted at any time and from time to time for a specified period or periods. Within ten (10) days from a denial of the written request of an insurer for an exemption from the Oklahoma Annual Financial Report Act, the insurer may request in writing a hearing on its application for an exemption. The hearing shall be held in accordance with the Administrative Procedures Act and the laws and rules of the Insurance Department.

B. Domestic insurers retaining a certified public accountant who qualify as independent on the effective date of the Oklahoma Annual Financial Report Act shall comply with the Oklahoma Annual Financial Report Act for the year ending December 31, 2010 and each year thereafter unless the Commissioner permits otherwise.

C. Domestic insurers not retaining a certified public accountant on the effective date of the Oklahoma Annual Financial Report Act who qualifies as independent may meet the following schedule for compliance unless the Commissioner permits otherwise:

1. As of December 31, 2010, file with the Commissioner an audited financial report; and

2. For the year ending December 31, 2011, and each year thereafter, such insurers shall file with the Commissioner all reports and communication required by the Oklahoma Annual Financial Report Act.

D. Foreign insurers shall comply with the Oklahoma Annual Financial Report Act for the year ending December 31, 2011, and each year thereafter, unless the Commissioner permits otherwise.

E. The requirements of subsection D of Section 9 of this act shall be in effect for audits of the year beginning January 1, 2010, and thereafter.

F. The requirements of Section 16 of this act are to be in effect January 1, 2010. An insurer or group of insurers that is not required to have independent audit committee members or only a majority of independent audit committee members, as opposed to a supermajority, because the total written and assumed premium is below the threshold and subsequently becomes subject to one of the independence requirements due to changes in premium shall have one (1) year following the year the threshold is exceeded, but not

earlier than January 1, 2010, to comply with the independence requirements. An insurer acquired as a result of a business combination shall have one (1) calendar year following the date of acquisition or combination to comply with the independence requirements.

G. The requirements of Section 18 of this act are effective beginning with the reporting period ending December 31, 2010, and each year thereafter. An insurer or group of insurers that are not required to file a report because the total written premium is below the threshold and subsequently becomes subject to the reporting requirements shall have two (2) years following the year the threshold is exceeded, but not earlier than December 31, 2010, to file a report. Likewise, an insurer acquired in a business combination shall have two (2) calendar years following the date of acquisition or combination to comply with the reporting requirements.

SECTION 20. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 311A.18 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. In the case of Canadian and British insurers, the annual audited financial report shall be defined as the annual statement of total business on the form filed by such companies with their supervision authority duly audited by an independent chartered accountant.

B. For such insurers, the letter required in subsection B of Section 8 of this act shall state that the accountant is aware of the requirements relating to the annual audited financial report filed with the Insurance Commissioner pursuant to Section 6 of this act and shall affirm that the opinion expressed is in conformity with those requirements.

SECTION 21. AMENDATORY 36 O.S. 2001, Section 361, as last amended by Section 2, Chapter 129, O.S.L. 2005 (36 O.S. Supp. 2008, Section 361), is amended to read as follows:

Section 361. A. There is hereby created within the Insurance Department, under the control and direction of the Insurance Commissioner, an "Anti-Fraud Unit" within the Legal and Investigation Division of the Insurance Department.

B. The Anti-Fraud Unit, upon inquiry, complaint, or referral shall investigate the extent, if any, to which a violation has occurred of any statute or administrative rule of this state pertaining to insurance fraud and may initiate any necessary investigation. Whenever the Unit determines that a violation of any criminal law of this state may have occurred, it may refer the matter to the Oklahoma State Bureau of Investigation for further investigation pursuant to Section 150.5 of Title 74 of the Oklahoma Statutes or the Attorney General pursuant to Section 18b of Title 74 of the Oklahoma Statutes. The Insurance Department shall retain the

authority to initiate and prosecute any civil action it deems necessary or advisable.

C. The Anti-Fraud Unit may employ investigators who are commissioned by the Insurance Commissioner to serve as peace officers, as defined by and pursuant to the guidelines and requirements of Section 3311 of Title 70 of the Oklahoma Statutes and Sections 99 and 99a of Title 21 of the Oklahoma Statutes.

D. Records, documents, reports and evidence obtained or created by the Anti-Fraud ~~Division~~ Unit as a result of an inquiry or investigation of suspected insurance fraud shall be confidential and shall not be subject to the Oklahoma Open Records Act or to outside review or release by any individual~~, but shall be subject to court order~~. Information and records shall be disclosed upon request to officers and agents of federal, state, county, or municipal law enforcement agencies, to the Oklahoma State Bureau of Investigation, to the Attorney General's office and to district attorneys, in the furtherance of criminal investigations.

SECTION 22. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1101.1 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. An Oklahoma domestic insurer possessing policyholder surplus of at least Fifteen Million Dollars ($15,000,000.00) may, pursuant to a resolution by its board of directors, and with the written approval of the Insurance Commissioner, be designated as a domestic

surplus line insurer. Such insurers shall write surplus line insurance in any jurisdiction within which it does business, including this state.

B. A domestic surplus line insurer may only insure in this state any risk procured pursuant to Article 11 of the Oklahoma Insurance Code governing surplus line insurers and brokers and its premium shall be subject to surplus line premium tax pursuant to Section 1115 of this title.

C. A domestic surplus line insurer may not issue a policy designed to satisfy the motor vehicle financial responsibility requirement of this state, the Oklahoma Workers' Compensation Act, or any other law mandating insurance coverage by a licensed insurance company.

D. A domestic surplus line insurer is not subject to the provisions of the Oklahoma Property & Casualty Insurance Guaranty Act nor the Oklahoma Life and Health Insurance Guaranty Association Act.

SECTION 23. AMENDATORY 36 O.S. 2001, Section 1219.4, as last amended by Section 9, Chapter 125, O.S.L. 2007 (36 O.S. Supp. 2008, Section 1219.4), is amended to read as follows:

Section 1219.4 A. As used in this section:

1. "Direct contract" means a contractual arrangement tying the ultimate seller purporting to offer discounts through the discount card to the health care provider, which expressly states the intent

of this agreement to be used for the purpose of offering discounts on health-related purchases to uninsured or noncovered persons;

2. "Discount card" means a card or any other purchasing mechanism or device, which is not insurance, that purports to offer discounts or access to discounts in health-related purchases from health care providers;

3. "Discount medical plan" means a business arrangement or contract in which a person, in exchange for fees, dues, charges, or other consideration, provides access for plan members to providers of medical services and the right to receive medical services from those providers at a discount. The term discount medical plan does not include any product regulated as an insurance product, group health service product or health maintenance organization (HMO) product in the State of Oklahoma or discounts provided by an insurer, group health service, or health maintenance organizations (HMOs) where those discounts are provided at no cost to the insured or member and are offered due to coverage with a licensed insurer, group health service, or HMO;

4. "Discount medical plan organization" means a person or an entity which operates a discount medical plan;

5. "Health care provider" means any person or entity licensed by this state to provide health care services including, but not limited to, physicians, hospitals, home health agencies, pharmacies, and dentists;

6. “Health care provider network” means an entity which directly contracts with physicians and hospitals and has contractual rights to negotiate on behalf of those health care providers with a discount medical plan organization to provide medical services to members of the discount medical plan organization;

7. "Marketer" means a person or entity who markets, promotes, sells or distributes a discount medical plan, including a private label entity that places its name on and markets or distributes a discount medical plan but does not operate a discount medical plan;

8. "Medical services" means any care, service or treatment of illness or dysfunction of, or injury to, the human body including, but not limited to, physician care, inpatient care, hospital surgical services, emergency services, ambulance services, dental care services, vision care services, mental health services, substance abuse services, chiropractic services, podiatric care services, laboratory services, and medical equipment and supplies. The term does not include pharmaceutical supplies or prescriptions;

9. "Member" means any person who pays fees, dues, charges, or other consideration for the right to receive the purported benefits of a discount medical plan; and

10. "Person" means an individual, corporation, business trust, estate, trust, partnership, association, joint venture, limited liability company, or any other government or commercial entity.

B. 1. Before doing business in this state as a discount medical plan organization, an entity shall be a corporation, limited liability corporation, partnership, limited liability partnership or other legal entity, organized under the laws of this state or, if a foreign entity, authorized to transact business in this state, and shall be registered as a discount medical plan organization with the Insurance Department of the State of Oklahoma or be licensed by the Insurance Department of the State of Oklahoma as a licensed insurance company, licensed HMO, licensed group health service organization or motor service club.

2. To register as a discount medical plan organization, an applicant shall:

a. file with the Insurance Department of the State of Oklahoma an application on the form that the Insurance Commissioner requires, and

b. pay to the Department an application fee of Two Hundred Fifty Dollars ($250.00).

3. A registration is valid for a one-year term.

4. A registration expires one year following the registration unless it is renewed as provided in this subsection.

5. Before it expires, a registrant may renew the registration for an additional one-year term if the registrant:

a. otherwise is entitled to be registered,

b. files with the Department a renewal application on the form that the Insurance Commissioner requires, and

c. pays to the Department a renewal fee of Two Hundred Fifty Dollars ($250.00).

6. The Insurance Commissioner may deny a registration to an applicant or refuse to renew, suspend, or revoke the registration of a registrant if the applicant or registrant, or an officer, director, or employee of the applicant or registrant:

a. makes a material misstatement or misrepresentation in an application for registration,

b. fraudulently or deceptively obtains or attempts to obtain a registration for the applicant or registrant or for another,

c. in connection with the administration of a health care discount program, commits fraud or engages in illegal or dishonest activities, or

d. has violated any provisions of this section.

7. Prior to registration by the Insurance Department of the State of Oklahoma, each discount medical plan organization shall establish an Internet web site.

8. All amounts collected as registration or renewal fees shall be deposited into the General Revenue Fund.

9. Nothing in this subsection shall require a provider who provides discounts to his or her own patients to obtain and maintain a registration as a discount medical plan organization.

10. a. Nothing in this subsection shall apply to an affiliate of a licensed insurance company, HMO, group health service organization or motor service club, provided that the affiliate registers with and maintains registration in good standing with the Insurance Department of the State of Oklahoma in accordance with subparagraphs b and c of this paragraph.

b. An affiliate shall register as a discount medical plan organization on a form prescribed by the Insurance Commissioner prior to the sale, marketing or solicitation of a discount medical plan and pay an application fee of One Hundred Dollars ($100.00).

c. A registration shall expire one (1) year after the date of registration, and each year on that date thereafter. A registrant may renew the registration if the registrant pays an annual registration fee of One Hundred Dollars ($100.00) and remains in good standing with the Insurance Department of the State of Oklahoma.

d. For purposes of this section, "affiliate" means a person that, directly or indirectly through one or

more intermediaries, controls or is controlled by or is under common control with an insurance company, HMO, group health service organization or motor service club licensed in this state.

C. 1. The Department may examine or investigate the business and affairs of any discount medical plan organization. The Department may require any discount medical plan organization or applicant to produce any records, books, files, advertising and solicitation materials, or other information and may take statements under oath to determine whether the discount medical plan organization or applicant is in violation of the law or is acting contrary to the public interest. The expenses incurred in conducting any examination or investigation shall be paid by the discount medical plan organization or applicant. Examinations and investigations shall be conducted as provided in Sections 309.1 and 309.3 through 309.7 of this title. Discount medical plan organizations shall be governed by the provisions of this section and shall not be subject to the provisions of the Insurance Code unless specifically referenced.

2. Failure by the discount medical plan organization to pay the expenses incurred under paragraph 1 of this subsection shall be grounds for denial or revocation of the discount medical plan organization's registration.

D. 1. A discount medical plan organization may charge a reasonable one-time processing fee and a periodic charge.

2. If the member cancels the membership within the first thirty (30) days after receipt of the discount card and other membership materials, the member shall receive a reimbursement of all periodic charges paid. The return of all periodic charges shall be made within thirty (30) days of the date of the cancellation. If all of the periodic charges have not been paid within thirty (30) days, interest shall be assessed and paid on the proceeds at a rate of the Treasury Bill rate of the preceding calendar year, plus two (2) percentage points.

3. The right of cancellation shall be set out in the contract on the first page, in ten-point type or larger.

4. If a discount medical plan charges for a time period in excess of one (1) month, the plan shall, in the event of cancellation of the membership by either party, make a pro rata reimbursement of all periodic charges to the member.

E. 1. A discount medical plan organization may not:

a. use in its advertisements, marketing material, brochures, and discount cards the terms “insurance”, "health plan", "coverage", "copay", "copayments", "preexisting conditions", "guaranteed issue", "premium", "PPO", "preferred provider organization”, or other terms in a manner that could reasonably

mislead a person to believe that the discount medical plan is health insurance,

b. except for hospital services, have restrictions on free access to plan providers including waiting periods and notification periods, or

c. pay providers any fees for medical services.

2. A discount medical plan organization may not collect or accept money from a member for payment to a provider for specific medical services furnished or to be furnished to the member unless the organization has an active license from the Insurance Department of the State of Oklahoma to act as an administrator.

F. 1. The following disclosures, to be printed in not less than twelve-point type, shall be made in writing to any prospective member and shall appear on the first page of any advertisements, marketing materials or brochures relating to a discount medical plan:

a. that the plan is not insurance,

b. that the plan provides discounts with certain health care providers for medical services,

c. that the plan does not make payments directly to the providers of medical services,

d. that the plan member is obligated to pay for all health care services but will receive a discount from

those health care providers who have contracted with the discount plan organization, and

e. the name and the location of the registered discount medical plan organization, including the current telephone number of the registered discount medical plan organization or other entity responsible for customer service for the plan, if different from the registered discount medical plan organization.

2. If the discount medical plan is sold, marketed, or solicited by telephone, the disclosures required by this section shall be made orally and provided in the initial written materials that describe the benefits under the discount medical plan provided to the prospective or new member.

3. The discount card provided to members shall prominently display the words "This is not insurance".

G. 1. All providers offering medical services to members under a discount medical plan shall provide such services pursuant to a written agreement. The agreement may be entered into directly by the health care provider or by a health care provider network to which the provider belongs if the provider network has contracts with the health care provider that allow the provider network to contract on behalf of the health care provider.

2. A health care provider agreement shall provide the following:

a. a description of the services and products to be provided at a discount,

b. the amount or amounts of the discounts or, alternatively, a fee schedule which reflects the health care provider's discounted rates, and

c. a provision that the health care provider will not charge members more than the discounted rates.

3. A health care provider agreement with a health care provider network shall require that the health care provider network have written agreements with its health care providers that:

a. contain the terms described in paragraph 2 of this subsection,

b. authorize the health care provider network to contract with the discount medical plan organization on behalf of the provider, and

c. require the network to maintain an up-to-date list of its contracted health care providers and to provide that list on a quarterly basis to the discount medical plan organization.

4. The discount medical plan organization shall maintain a copy of each active health care provider agreement into which it has entered.

H. 1. There shall be a written agreement between the discount medical plan organization and the member specifying the benefits

under the discount medical plan and complying with the disclosure requirements of this section.

2. All forms used, including the written agreement pursuant to the provisions of ~~paragraph 2 of this~~ subsection G of this section, shall first be filed with the Department. Every form filed shall be identified by a unique form number placed in the lower left corner of each form. A filing fee of Twenty-five Dollars ($25.00) per form shall be payable to the Insurance Department of the State of Oklahoma for deposit into the General Revenue Fund.

I. 1. Each discount medical plan organization required to be registered pursuant to this section except an affiliate shall, at all times, maintain a net worth of at least One Hundred Fifty Thousand Dollars ($150,000.00).

2. The Insurance Department of the State of Oklahoma may not allow a registration unless the discount medical plan organization has a net worth of at least One Hundred Fifty Thousand Dollars ($150,000.00).

J. 1. The Insurance Department of the State of Oklahoma may suspend the authority of a discount medical plan organization to enroll new members, revoke any registration issued to a discount medical plan organization, or order compliance if the Department finds that any of the following conditions exist:

a. the organization is not operating in compliance with the provisions of this section,

b. the organization does not have the minimum net worth as required by this section,

c. the organization has advertised, merchandised or attempted to merchandise its services in such a manner as to misrepresent its services or capacity for service or has engaged in deceptive, misleading or unfair practices with respect to advertising or merchandising,

d. the organization is not fulfilling its obligations as a discount medical plan organization, or

e. the continued operation of the organization would be hazardous to its members.

2. If the Insurance Department of the State of Oklahoma has cause to believe that grounds for the suspension or revocation of a registration exist, the Department shall notify the discount medical plan organization in writing, specifically stating the grounds for suspension or revocation, and shall provide opportunity for a hearing on the matter in accordance with the Administrative Procedures Act and the Oklahoma Insurance Code.

3. When the <u>certificate of</u> registration of a discount medical plan organization is <u>nonrenewed,</u> surrendered or revoked, such organization shall proceed, immediately following the effective date of the order of revocation, <u>or in the case of nonrenewal, the date of expiration of the certificate of registration,</u> to wind up its

affairs transacted under the certificate of registration. The organization may not engage in any further advertising, solicitation, collecting of fees, or renewal of contracts.

4. The Insurance Department of the State of Oklahoma shall, in its order suspending the authority of a discount medical plan organization to enroll new members, specify the period during which the suspension is to be in effect and the conditions, if any, which shall be met by the discount medical plan organization prior to reinstatement of its registration to enroll new members. The order of suspension is subject to rescission or modification by further order of the Department prior to the expiration of the suspension period. Reinstatement may not be made unless requested by the discount medical plan organization; however, the Department may not grant reinstatement if it finds that the circumstances for which the suspension occurred still exist or are likely to reoccur.

K. Each discount medical plan organization required to be registered pursuant to this section shall provide the Insurance Department of the State of Oklahoma at least thirty (30) days' advance notice of any change in the discount medical plan organization's name, address, principal business address, or mailing address.

L. Each discount medical plan organization shall maintain an up-to-date list of the names and addresses of the providers with which it has contracted on an Internet web site page, the address of

which shall be prominently displayed on all its advertisements, marketing materials, brochures, and discount cards. This section applies to those providers with whom the discount medical plan organization has contracted directly, as well as those who are members of a provider network with which the discount medical plan organization has contracted.

M. 1. All advertisements, marketing materials, brochures and discount cards used by marketers shall be approved in writing for such use by the discount medical plan organization.

2. The discount medical plan organization shall have an executed written agreement with a marketer prior to the marketer's marketing, promoting, selling, or distributing the discount medical plan.

N. The Insurance Commissioner may promulgate rules to administer the provisions of this section.

O. Regulation of discount medical plan organizations shall be done pursuant to the Administrative Procedures Act.

P. 1. A discount medical plan organization required to be registered pursuant to this section except an affiliate shall maintain a surety bond with the Insurance Department of the State of Oklahoma, having at all times a value of not less than Thirty-five Thousand Dollars ($35,000.00), for use by the Department in protecting plan members.

2. No judgment creditor or other claimant of a discount medical plan organization, other than the Insurance Department of the State of Oklahoma, shall have the right to levy upon the surety bond held pursuant to the provisions of paragraph 1 of this subsection.

Q. 1. A person who knowingly and willfully operates as or aids and abets another operating as a discount medical plan organization in violation of subsection B of this section commits a felony, punishable as provided for in Oklahoma law, as if the discount medical plan organization were an unauthorized insurer, and the fees, dues, charges, or other consideration collected from the members by the discount medical plan organization or marketer were insurance premium.

2. A person who collects fees for purported membership in a discount medical plan but fails to provide the promised benefits commits a theft, punishable as provided in Oklahoma law.

R. 1. In addition to the penalties and other enforcement provisions of this section, the Department may seek both temporary and permanent injunctive relief if:

a. a discount medical plan organization is being operated by any person or entity that is not registered pursuant to this section, or

b. any person, entity, or discount medical plan organization has engaged in any activity prohibited by

this section or any rule adopted pursuant to this section.

2. The venue for any proceeding brought pursuant to the provisions of this section shall be in the district court of Oklahoma County.

S. 1. The provisions of this section apply to the activities of a discount medical plan organization that is not registered pursuant to this section as if the discount medical plan organization were an unauthorized insurer.

2. A discount medical plan organization being operated by any person or entity that is not registered pursuant to this section, or any person, entity or discount medical plan organization that has engaged or is engaging in any activity prohibited by this section or any rules adopted pursuant to this section shall be subject to the Unauthorized Insurer Act as if the discount medical plan organization were an unauthorized insurer, and shall be subject to all the remedies available to the Insurance Commissioner under the Unauthorized Insurer Act.

T. If the Insurance Commissioner finds that a discount medical plan organization has violated any provision of this section or that grounds exist for the discretionary revocation or suspension of a registration, the Commissioner, in lieu of such revocation or suspension, may impose a fine upon the discount medical plan

organization in an amount not to exceed One Thousand Dollars ($1,000.00) per violation.

SECTION 24. AMENDATORY 36 O.S. 2001, Section 1435.6, as last amended by Section 44, Chapter 264, O.S.L. 2006 (36 O.S. Supp. 2008, Section 1435.6), is amended to read as follows:

Section 1435.6 A. A resident individual applying for an insurance producer license shall pass a written examination unless exempt pursuant to Section 1435.10 of this title. The examination shall test the knowledge of the individual concerning the lines of authority for which application is made, the duties and responsibilities of an insurance producer and the insurance laws and regulations of this state. Examinations required by this section shall be developed and conducted under rules and regulations prescribed by the Insurance Commissioner.

B. The Commissioner may make arrangements, including contracting with an outside testing service, for administering examinations and collecting the nonrefundable fee set forth in Section 1435.23 of this title.

C. Each individual applying for an examination shall remit a nonrefundable fee as prescribed by the Insurance Commissioner as set forth in Section 1435.23 of this title.

D. After completion and filing of the application with the Insurance Commissioner, except as provided in Section 1435.10 of this title, the Commissioner shall subject each applicant for

license as an insurance agent, insurance consultant, limited insurance representative, or customer service representative to an examination approved by the Commissioner as to competence to act as a licensee, which each applicant shall personally take and pass to the satisfaction of the Commissioner. The Commissioner may accept examinations administered by a testing service as satisfying the examination requirements of persons seeking license as agents, solicitors, counselors, or adjusters under the Oklahoma Insurance Code. The Commissioner may negotiate agreements with such testing services to include performance of examination development, test scheduling, examination site arrangements, test administration, grading, reporting, and analysis. The Commissioner may require such testing services to correspond directly with the applicants with regard to the administration of such examinations and that such testing services collect fees for administering such examinations directly from the applicants. The Commissioner may stipulate that any agreements with such testing services provide for the administration of examinations in specific locales and at specified frequencies. The Commissioner shall retain the authority to establish the scope and type of all examinations.

E. If the applicant is a legal entity, the examination shall be taken by each individual who is to act for the entity as a licensee.

F. Each examination for a license shall be approved for use by the Commissioner and shall reasonably test the knowledge of the

applicant as to the lines of insurance, policies, and transactions to be handled pursuant to the license applied for, the duties and responsibilities of the licensee, and the pertinent insurance laws of this state.

G. Examination for licensing shall be at such reasonable times and places as are designated by the Commissioner.

H. The Commissioner or testing service shall give, conduct, and grade all examinations in a fair and impartial manner and without discrimination among individuals examined.

I. The applicant shall pass the examination with a grade determined by the Commissioner to indicate satisfactory knowledge and understanding of the line or lines of insurance for which the applicant seeks qualification. Within ten (10) days after the examination, the Commissioner shall inform the applicant and the appointing insurer, when applicable, as to whether or not the applicant has passed. Formal evidence of licensing shall be issued by the Commissioner to the licensee within a reasonable time.

J. An applicant who has failed to pass the first examination for the license applied for may take a second examination within thirty (30) days following the first examination. Examination fees for subsequent examinations shall not be waived.

K. An applicant who has failed to pass the first two examinations for the license applied for shall not be permitted to take a subsequent examination until the expiration of thirty (30)

days after the last previous examination. An applicant shall take and pass the examination within one hundred eighty (180) days of the date of the initial application. If applicant fails to pass the examination within the specified time period, the applicant shall submit a new application accompanied by any applicable fees. Examination fees for subsequent examinations shall not be waived.

L. An applicant for a license as a resident surplus lines broker shall have passed the property and casualty insurance examination on the line or lines of insurance to be written to qualify for a surplus lines broker license.

SECTION 25. AMENDATORY 36 O.S. 2001, Section 1435.7, as last amended by Section 10, Chapter 184, O.S.L. 2008 (36 O.S. Supp. 2008, Section 1435.7), is amended to read as follows:

Section 1435.7 A. A person applying for a resident insurance producer license shall make application to the Insurance Commissioner on the Uniform Application or an application approved by the Commissioner and declare under penalty of refusal, suspension or revocation of the license that the statements made in the application are true, correct and complete to the best of the individual's knowledge and belief. Before approving the application, the Insurance Commissioner shall find that the individual:

1. Is at least eighteen (18) years of age;

2. Has not committed any act that is a ground for denial, suspension or revocation set forth in Section 1435.13 of this title;

3. Has held a provisional insurance producer license or has been a participant in an approved training program offered by an insurance company licensed in this state except for title, aircraft title, or any other producer applicant exempt by rule;

4. Has paid the fees set forth in Section 1435.23 of this title; and

5. Has successfully passed the examinations for the lines of authority for which the person has applied.

B. A business entity acting as an insurance producer is required to obtain an insurance producer license. Application shall be made using the Uniform Business Entity Application or an application approved by the Commissioner. Before approving the application, the Insurance Commissioner shall find that:

1. The business entity has paid the fees set forth in Section 1435.23 of this title;

2. The business entity has designated a licensed producer responsible for the business entity's compliance with the insurance laws, rules and regulations of this state;

3. A domestic business entity is organized pursuant to the provisions of the laws of this state and maintains its principal place of business in this state; and

4. No person whose license as an insurance producer has been revoked by order of the Commissioner, nor any business entity in which such person has a majority ownership interest, whether direct or indirect, owns any interest in the business entity licensed as an insurance producer.

C. ~~A business entity acting as an insurance producer shall notify the Commissioner of all changes among its members, directors and officers and all other individuals designated in the license within fifteen (15) days after the change.~~

~~D.~~ An applicant for any license required by the provisions of the Oklahoma Producer Licensing Act shall demonstrate to the Insurance Commissioner that the applicant is competent, trustworthy, financially responsible, and of good personal and business reputation.

~~E.~~ D. The Insurance Commissioner may require any documents reasonably necessary to verify the information contained in an application.

SECTION 26. AMENDATORY 36 O.S. 2001, Section 1435.8, as last amended by Section 45, Chapter 264, O.S.L. 2006 (36 O.S. Supp. 2008, Section 1435.8), is amended to read as follows:

Section 1435.8 A. Unless denied licensure pursuant to Section 1435.13 of this title, persons who have met the requirements of Sections 1435.6 and 1435.7 of this title shall be issued an insurance producer license. An insurance producer may receive

qualification for a license in one or more of the following lines of authority:

1. Life - insurance coverage on human lives including benefits of endowment and annuities, and may include benefits in the event of death or dismemberment by accident and benefits for disability income;

2. Accident and health or sickness - insurance coverage for sickness, bodily injury or accidental death and may include benefits for disability income;

3. Property - insurance coverage for the direct or consequential loss or damage to property of every kind;

4. Casualty - insurance coverage against legal liability, including that for death, injury or disability or damage to real or personal property;

5. Variable life and variable annuity products - insurance coverage provided under variable life insurance contracts and variable annuities;

6. Personal lines - property and casualty insurance coverage sold to individuals and families for primarily noncommercial purposes;

7. Commercial lines – property and casualty insurance coverage sold to businesses for primarily commercial purposes;

8. Credit - limited line credit insurance;

9. Title insurance – insurance coverage that insures or guarantees the title to real or personal property or any interest therein or encumbrance thereon;

10. Aircraft title insurance – insurance coverage that protects an aircraft owner or lender against loss of the aircraft or priority security position in the event of a successful adverse claim on the title to an aircraft; and

11. Any other line of insurance permitted under state laws or regulations.

B. An insurance producer license shall remain in effect unless revoked or suspended as long as the fee set forth in Section 1435.23 of this title is paid and education requirements for resident individual producers are met by the due date.

C. An individual insurance producer who allows the license to lapse may, within twenty-four (24) months from the due date of the renewal fee, reinstate the same license without the necessity of passing a written examination unless the license was revoked, suspended, or continuation thereof was refused by the Commissioner. However, a penalty in the amount of double the unpaid renewal fee shall be required for any renewal fee received after the due date. Continuing education requirements must be kept current.

D. A licensed insurance producer who is unable to comply with license renewal procedures due to military service or some other extenuating circumstance, such as a long-term medical disability,

may request a waiver of those procedures. The producer may also request a waiver of any examination requirement or any other fine or sanction imposed for failure to comply with renewal procedures.

E. The license shall contain the licensee's name, address, personal identification number, and the date of issuance, the lines of authority, the expiration date and any other information the Insurance Commissioner deems necessary.

F. Licensees shall inform the Insurance Commissioner by any means acceptable to the Insurance Commissioner of a change of legal name or address within thirty (30) days of the change. ~~Failure to timely inform the Insurance Commissioner of a~~ A change in legal name or address ~~shall result in a penalty~~ submitted more than thirty (30) days after the change must include an administrative fee of Fifty Dollars ($50.00). Failure to provide acceptable notification of a change of legal name or address to the Insurance Commissioner within forty-five (45) days of the date the administrative fee is assessed will result in penalties pursuant to Section 1435.13 of this title.

G. In order to assist in the performance of the Insurance Commissioner's duties, the Insurance Commissioner may contract with nongovernmental entities, including the National Association of Insurance Commissioners (NAIC) or any affiliates or subsidiaries that the NAIC oversees, to perform any ministerial functions, including the collection of fees, related to producer licensing that

the Insurance Commissioner and the nongovernmental entity may deem appropriate.

H. The Commissioner may participate, in whole or in part, with the National Association of Insurance Commissioners, or any affiliates or subsidiaries the National Association of Insurance Commissioners oversees, in a centralized producer license registry where insurance producer licenses and appointments may be centrally or simultaneously effected for all states that require an insurance producer license and participate in such centralized producer license registry. If the Commissioner finds that participation in such a centralized producer license registry is in the public interest, the Commissioner may adopt by rule any uniform standards or procedures as are necessary to participate in the registry. This includes the central collection of all fees for licenses or appointments that are processed through the registry.

SECTION 27. AMENDATORY 36 O.S. 2001, Section 1435.10, as amended by Section 46, Chapter 264, O.S.L. 2006 (36 O.S. Supp. 2008, Section 1435.10), is amended to read as follows:

Section 1435.10 A. The following are exempt from the requirement for an examination, if the Insurance Commissioner determines, in accordance with rules adopted by the Commissioner, that the applicant is cognizant of and capable of fulfilling the responsibilities of the license:

1. Any limited lines producer; and

2. ~~A surplus lines insurance broker; and~~

~~3.~~ A title insurance producer licensed prior to November 1, 2006, who is an applicant for an aircraft title producer license.

B. A person licensed as an insurance producer in another state who moves to this state shall make application to become a resident licensee within ninety (90) days of establishing legal residence in Oklahoma. No examination or continuing education shall be required of that person to obtain resident licensing for any line of authority held by the licensee in the prior state on the date legal residency was established in this state, except where the Insurance Commissioner determines otherwise by regulation.

SECTION 28. AMENDATORY 36 O.S. 2001, Section 1435.15, as last amended by Section 13, Chapter 125, O.S.L. 2007 (36 O.S. Supp. 2008, Section 1435.15), is amended to read as follows:

Section 1435.15 A. An insurance producer shall not act as an agent of an insurer unless the insurance producer becomes an appointed agent of that insurer. An insurance producer who is not acting as an agent of an insurer is not required to become appointed.

B. To appoint a producer as its agent, the appointing insurer, or an authorized representative of the insurer, shall file, in a format approved by the Insurance Commissioner, a notice of appointment within fifteen (15) days from the date the agency contract is executed or the first insurance application is

submitted. For purposes of this section, an "authorized representative of the insurer" means a person or entity licensed by the Insurance Commissioner pursuant to the laws of this state who is authorized in writing by the appointing insurer to file appointments for the appointing insurer. ~~A copy of said written authorization shall accompany each notice of appointment filed by an authorized representative of the insurer.~~ An insurer or authorized representative of an insurer may also elect to appoint a producer to all or some insurers within the insurer's holding company system or group by the filing of a single appointment request.

C. Upon receipt of the notice of appointment, the Insurance Commissioner shall verify within a reasonable time not to exceed thirty (30) days that the insurance producer is eligible for appointment. If the insurance producer is determined to be ineligible for appointment, the Insurance Commissioner shall notify the insurer and the authorized representative of the insurer within five (5) days of its determination.

D. An insurer or authorized representative of an insurer shall pay a biennial appointment fee, in the amount and method of payment set forth in Section 1435.23 of this title, for each insurance producer appointed by the insurer for each insurer for which the insurance producer is appointed.

E. It shall be unlawful for any insurer to discriminate among or between the insurance producers it has appointed. Any person or

company convicted of violating the provisions of this section shall be guilty of a misdemeanor and shall be punished by the imposition of a fine of not more than Five Hundred Dollars ($500.00) or imprisonment in the county jail for not less than six (6) months nor more than one (1) year, or be punished by both said fine and imprisonment.

SECTION 29. AMENDATORY 36 O.S. 2001, Section 1435.23, as last amended by Section 13, Chapter 184, O.S.L. 2008 (36 O.S. Supp. 2008, Section 1435.23), is amended to read as follows:

Section 1435.23 A. All applications shall be accompanied by the applicable fees. An appointment may be deemed by the Commissioner to have terminated upon failure by the insurer to pay the prescribed renewal fee. The Commissioner may also by order impose a civil penalty equal to double the amount of the unpaid renewal fee.

The Insurance Commissioner shall collect in advance the following fees and licenses:

1. For filing appointment of Insurance Commissioner as agent for service of process..... $ 20.00

2. Miscellaneous:

a. Certificate and Clearance of Commissioner..... $ 3.00

b. Insurance producer's study manual:

Life, Accident & Health..... not to exceed

$ 40.00

Property and Casualty..... not to exceed

$ 40.00

c. For filing organizational documents of an entity applying for a license as an insurance producer..... $ 20.00

3. Examination for license:

For each examination covering laws and one or more lines of insurance.... not to exceed

$100.00

4. Licenses:

a. Insurance producer’s biennial license, regardless of number of companies represented..... $ 60.00

b. Insurance producer’s biennial license for sale or solicitation of separate accounts or agreements, as provided for in Section 6061 of this title..... $ 60.00

c. Limited lines producer biennial license..... $ 40.00

d. Temporary license as agent..... $ 20.00

e. Managing general agent's biennial license..... $ 60.00

f. Surplus lines broker's biennial license..... $100.00

g. Insurance vending machine, each machine, biennial fee..... $100.00

h. Insurance consultant's biennial license, resident or nonresident..... $100.00

i. Customer service representative biennial license..... $ 40.00

j. Insurance producer's provisional license $ 20.00

5. Biennial fee for each appointed insurance producer, managing general agent, or limited lines producer by insurer, each license of each insurance producer or representative..... $ 40.00

6. Renewal fee for all licenses shall be the same as the current initial license fee.

7. The fee for a duplicate license shall be one-half (1/2) the fee of an original license.

8. The renewal of a license shall require a fee of double the current original license fee if the application for renewal is late, or incomplete on the renewal deadline.

9. The administrative fee for submission of a change of legal name or address more than thirty (30) days after the change occurred shall be Fifty Dollars ($50.00).

B. 1. The fees and monies received by the Insurance Commissioner pursuant to the provisions of paragraphs 1, 2, 7 ~~and~~, 8 and 9 of subsection A of this section shall be deposited with the

State Treasurer, who shall place the same to the credit of the State Insurance Commissioner Revolving Fund for the purpose of fulfilling and accomplishing the conditions and purposes of the Oklahoma Producer Licensing Act, including the use of postal mail facilities for the Department.

2. The fees and monies received by the Insurance Commissioner pursuant to the provisions of paragraphs 3 through 6 of subsection A of this section shall be paid into the State Treasury to the credit of the General Revenue Fund of the state.

C. There is hereby created in the State Treasury the State Insurance Commissioner Revolving Fund which shall be a continuing fund not subject to fiscal year limitations. The revolving fund shall consist of fees and monies received by the Insurance Commissioner as required by law to be deposited in said fund and any other funds not dedicated in the Oklahoma Insurance Code. The revolving fund shall be used to fund the general operations of the Insurance Commissioner's Office for the purpose of fulfilling and accomplishing the conditions and purposes of the Oklahoma Producer Licensing Act. All expenditures from said revolving fund shall be on claims approved by the Insurance Commissioner and filed with the Director of State Finance for payment.

D. All fees, fines, monies, and license fees authorized by the provisions of this section and not dedicated by the provisions of subsection B of this section to the State Insurance Commissioner

Revolving Fund shall be paid into the State Treasury to the credit of the General Revenue Fund of this state.

E. If for any reason an insurance producer license or appointment is not issued or renewed by the Commissioner, all fees accompanying the appointment or application for the license shall be deemed earned and shall not be refundable except as provided in Section 352 of this title.

F. The Insurance Commissioner, by order, may waive licensing fees in extraordinary circumstances for a class of producers where the Commissioner deems that the public interest will be best served.

SECTION 30. AMENDATORY 36 O.S. 2001, Section 1435.29, as last amended by Section 14, Chapter 184, O.S.L. 2008 (36 O.S. Supp. 2008, Section 1435.29), is amended to read as follows:

Section 1435.29 A. 1. Each insurance producer, with the exception of title producers and aircraft title producers or any other producer exempt by rule, shall, biennially, complete not less than ~~fourteen (14)~~ twenty-one (21) clock hours of continuing insurance education which shall cover subjects in the lines for which the insurance producer is licensed. Such education may include a written or oral examination.

2. Each customer service representative shall, biennially, complete not less than ten (10) clock hours of continuing insurance education which shall cover subjects in the lines for which the

licensee is authorized to conduct insurance-related business on behalf of the appointing agent, broker, or agency.

3. Licensees, with the exception of title producers and aircraft title producers or any other producer exempt by rule, shall complete, in addition to the foregoing, ~~two (2)~~ three (3) clock hours of ethics course work in this same period.

4. Each title producer and aircraft title producer shall, biennially, complete not less than sixteen (16) clock hours of continuing insurance education, two (2) hours of which shall be ethics course work, which shall cover the line for which the producer is licensed. Such education may include a written or oral examination.

B. 1. The Insurance Commissioner shall approve courses and providers of resident provisional producer prelicensing education and continuing education. The Insurance Department may use one or more of the following to review and provide a nonbinding recommendation to the Insurance Commissioner on approval or disapproval of courses and providers of resident provisional producer prelicensing education and continuing education:

a. employees of the Insurance Commissioner,

b. a continuing education advisory committee, or

c. an independent service whose normal business activities include the review and approval of continuing education courses and providers. The

Commissioner may negotiate agreements with such independent service to review documents and other materials submitted for approval of courses and providers and provide the Commissioner with its nonbinding recommendation. The Commissioner may require such independent service to collect the fee charged by the independent service for reviewing materials provided for review directly from the course providers.

The Insurance Commissioner has sole authority to approve courses and providers of resident provisional producer prelicensing education and continuing education. If the Insurance Commissioner uses one of the entities listed above to provide a nonbinding recommendation, the Commissioner shall adopt or decline to adopt the recommendation within thirty (30) days of receipt of the recommendation. In the event the Insurance Commissioner takes no action within said thirty-day period, the recommendation made to the Commissioner will be deemed to have been adopted by the Commissioner.

The Insurance Commissioner may certify providers and courses offered for license examination study. The Insurance Department shall use employees of the Insurance Commissioner to review and certify license examination study program providers and courses.

2. Each insurance company shall be allowed to provide continuing education to insurance producers and customer service representatives as required by this section; provided that such continuing education meets the general standards for education otherwise established by the Insurance Commissioner.

3. An insurance producer who, during the time period prior to renewal, participates in an approved professional designation program shall be deemed to have met the biennial requirement for continuing education.

Each course in the curriculum for the program shall total a minimum of ~~twenty (20)~~ twenty-four (24) hours. Each approved professional designation program included in this section shall be reviewed for quality and compliance every three (3) years in accordance with standardized criteria promulgated by rule. Continuation of approved status is contingent upon the findings of the review. The list of professional designation programs approved under this paragraph shall be made available to producers and providers annually.

4. The Insurance Department may promulgate rules providing that courses or programs offered by professional associations shall qualify for presumptive continuing education credit approval. The rules shall include standardized criteria for reviewing the professional associations' mission, membership, and other relevant information, and shall provide a procedure for the Department to

disallow all or part of a presumptively approved course. Professional association courses approved in accordance with this paragraph shall be reviewed every three (3) years to determine whether they continue to qualify for continuing education credit.

5. Subject to approval by the Commissioner, the active membership of the licensed producer or broker in local, regional, state, or national professional insurance organizations or associations may be approved for up to one (1) annual hour of instruction. The hour shall be credited upon timely filing with the Commissioner, or designee of the Commissioner, and appropriate written evidence acceptable to the Commissioner of such active membership in the organization or association.

6. The active service of a licensed producer as a member of a continuing education advisory committee, as described in paragraph 1 of this subsection, shall be deemed to qualify for continuing education credit on an hour-for-hour basis.

C. ~~Each provider of resident provisional producer prelicensing education and continuing education shall, after approval by the Commissioner, submit an annual fee. A fee may be assessed for each course submission at the time it is first submitted for review and upon submission for renewal at expiration.~~ Annual fees and course submission fees shall be set forth as a rule by the Commissioner. The fees are payable to the Insurance Commissioner which shall be deposited in the State Insurance Commissioner Revolving Fund,

created in subsection C of Section 1435.23 of this title, for the purposes of fulfilling and accomplishing the conditions and purposes of the Oklahoma Producer Licensing Act and the Insurance Adjusters Licensing Act. Provided, public-funded educational institutions, federal agencies, nonprofit organizations, not-for-profit organizations, and Oklahoma state agencies shall be exempt from this subsection.

D. Failure of an insurance producer or customer service representative to comply with the requirements of the Oklahoma Producer Licensing Act may, after notice and opportunity for hearing, result in censure, suspension, nonrenewal of license or a civil penalty of up to Five Hundred Dollars ($500.00) or by both such penalty and civil penalty. Said civil penalty may be enforced in the same manner in which civil judgments may be enforced. Any civil penalties collected under this act shall be deposited in the State Insurance Commissioner Revolving Fund.

E. Limited lines producers and nonresident agents who have successfully completed an equivalent or greater requirement shall be exempt from the provisions of this section.

F. ~~Insurance producers and limited lines producers who are sixty-five (65) years of age or older and who have at least thirty (30) years of experience as insurance producers or limited lines producers, and who do not write new business, shall be exempt from the provisions of this section.~~

~~G.~~ Members of the Legislature shall be exempt from this section.

~~H.~~ G. The Commissioner shall adopt and promulgate such rules as are necessary for effective administration of this section.

SECTION 31. AMENDATORY 36 O.S. 2001, Section 3636, as amended by Section 25, Chapter 519, O.S.L. 2004 (36 O.S. Supp. 2008, Section 3636), is amended to read as follows:

Section 3636. A. No policy insuring against loss resulting from liability imposed by law for bodily injury or death suffered by any person arising out of the ownership, maintenance or use of a motor vehicle shall be issued, delivered, renewed, or extended in this state with respect to a motor vehicle registered or principally garaged in this state unless the policy includes the coverage described in subsection B of this section.

B. The policy referred to in subsection A of this section shall provide coverage therein or supplemental thereto for the protection of persons insured thereunder who are legally entitled to recover damages from owners or operators of uninsured motor vehicles and hit-and-run motor vehicles because of bodily injury, sickness or disease, including death resulting therefrom. Coverage shall be not less than the amounts or limits prescribed for bodily injury or death for a policy meeting the requirements of Section 7-204 of Title 47 of the Oklahoma Statutes, as the same may be hereafter amended; provided, however, that increased limits of liability shall

be offered and purchased if desired, not to exceed the limits provided in the policy of bodily injury liability of the insured. The uninsured motorist coverage shall be upon a form approved by the Insurance Commissioner as otherwise provided in the Insurance Code and may provide that the parties to the contract shall, upon demand of either, submit their differences to arbitration; provided, that if agreement by arbitration is not reached within three (3) months from date of demand, the insured may sue the tort-feasor.

C. For the purposes of this coverage the term "uninsured motor vehicle" shall include an insured motor vehicle where the liability insurer thereof is unable to make payment with respect to the legal liability of its insured within the limits specified therein because of insolvency. For the purposes of this coverage the term "uninsured motor vehicle" shall also include an insured motor vehicle, the liability limits of which are less than the amount of the claim of the person or persons making such claim, regardless of the amount of coverage of either of the parties in relation to each other.

D. An insurer's insolvency protection shall be applicable only to accidents occurring during a policy period in which its insured's uninsured motorist coverage is in effect where the liability insurer of the tort-feasor becomes insolvent within one (1) year after such an accident. Nothing herein contained shall be construed to prevent

any insurer from according insolvency protection under terms and conditions more favorable to its insured than is provided hereunder.

E. For purposes of this section, there is no coverage for any insured while occupying a motor vehicle owned by, or furnished or available for the regular use of the named insured, a resident spouse of the named insured, or a resident relative of the named insured, if such motor vehicle is not insured by a motor vehicle insurance policy.

F. In the event of payment to any person under the coverage required by this section and subject to the terms and conditions of such coverage, the insurer making such payment shall, to the extent thereof, be entitled to the proceeds of any settlement or judgment resulting from the exercise of any rights of recovery of such person against any person or organization legally responsible for the bodily injury for which such payment is made, including the proceeds recoverable from the assets of the insolvent insurer. Provided, however, with respect to payments made by reason of the coverage described in subsection C of this section, the insurer making such payment shall not be entitled to any right of recovery against such tort-feasor in excess of the proceeds recovered from the assets of the insolvent insurer of said tort-feasor. Provided further, that any payment made by the insured tort-feasor shall not reduce or be a credit against the total liability limits as provided in the insured's own uninsured motorist coverage. Provided further, that

if a tentative agreement to settle for liability limits has been reached with an insured tort-feasor, written notice shall be given by certified mail to the uninsured motorist coverage insurer by its insured. Such written notice shall include:

1. Written documentation of pecuniary losses incurred, including copies of all medical bills; and

2. Written authorization or a court order to obtain reports from all employers and medical providers. Within sixty (60) days of receipt of this written notice, the uninsured motorist coverage insurer may substitute its payment to the insured for the tentative settlement amount. The uninsured motorist coverage insurer shall then be entitled to the insured's right of recovery to the extent of such payment and any settlement under the uninsured motorist coverage. If the uninsured motorist coverage insurer fails to pay the insured the amount of the tentative tort settlement within sixty (60) days, the uninsured motorist coverage insurer has no right to the proceeds of any settlement or judgment, as provided herein, for any amount paid under the uninsured motorist coverage.

G. A named insured or applicant shall have the right to reject uninsured motorist coverage in writing, and except that unless a named insured or applicant requests such coverage in writing, such coverage need not be provided in or supplemental to any renewal, reinstatement, substitute, amended or replacement policy where a

named insured or applicant had rejected the coverage in connection with a policy previously issued to him by the same insurer.

H. Notwithstanding the provisions of this section, the following are the only instances in which a new form affecting uninsured motorist coverage shall be required:

1. When an insurer is notified of a change in or an additional named insured;

2. When there is an additional vehicle that is not a replacement vehicle; provided, a new form shall not be required for the addition, substitution or deletion of a vehicle from a commercial automobile liability policy; or

3. When the amount of bodily injury liability coverage is amended. Provided, any change in premium alone shall not require the issuance of a new form.

After selection of limits, rejection, or exercise of the option not to purchase uninsured motorist coverage by a named insured or applicant for insurance, the insurer shall not be required to notify any insured in any renewal, reinstatement, substitute, amended or replacement policy as to the availability of such uninsured motorist coverage or such optional limits. Such selection, rejection, or exercise of the option not to purchase uninsured motorist coverage by a named insured or an applicant shall be valid for all insureds under the policy and shall continue until a named insured requests

in writing that the uninsured motorist coverage be added to an existing or future policy of insurance.

I. ~~Effective for forms required before April 1, 2005, the offer of the coverage required by subsection B of this section shall be in the following form which shall be filed with and approved by the Insurance Commissioner. The form shall be provided to the proposed insured in writing separately from the application and shall read substantially as follows:~~

~~OKLAHOMA UNINSURED MOTORIST COVERAGE LAW~~

~~Oklahoma law gives you the right to buy Uninsured Motorist coverage in the same amount as your bodily injury liability coverage. THE LAW REQUIRES US TO ADVISE YOU OF THIS VALUABLE RIGHT FOR THE PROTECTION OF YOU, MEMBERS OF YOUR FAMILY, AND OTHER PEOPLE WHO MAY BE HURT WHILE RIDING IN YOUR INSURED VEHICLE. YOU SHOULD SERIOUSLY CONSIDER BUYING THIS COVERAGE IN THE SAME AMOUNT AS YOUR LIABILITY INSURANCE COVERAGE LIMIT.~~

~~Uninsured Motorist coverage, unless otherwise provided in your policy, pays for bodily injury damages to you, members of your family who live with you, and other people riding in your car who are injured by: (1) an uninsured motorist, (2) a hit and run motorist, or (3) an insured motorist who does not have enough liability insurance to pay for bodily injury damages to any insured person. Uninsured Motorist coverage, unless otherwise provided in your policy, protects you and family members who live with you while~~

~~riding in any vehicle or while a pedestrian. THE COST OF THIS COVERAGE IS SMALL COMPARED WITH THE BENEFITS!~~

~~You may make one of four choices about Uninsured Motorist Coverage:~~

~~1. You may buy Uninsured Motorist coverage equal to your bodily injury liability coverage for $_____ for ____ months.~~

~~2. You may buy Uninsured Motorist coverage in the amount of $10,000.00 for each person injured, not to exceed $20,000.00 for two or more persons injured in one occurrence (the smallest coverage which Oklahoma law allows) for $_____ for ____ months.~~

~~3. You may buy Uninsured Motorist coverage in an amount less than your bodily injury liability coverage but more than the minimum levels.~~

~~4. You may reject Uninsured Motorist coverage.~~

~~Please indicate below what Uninsured Motorist coverage you want:~~

~~____ I want the same amount of Uninsured Motorist coverage as my bodily injury liability coverage.~~

~~____ I want minimum Uninsured Motorist coverage ($10,000.00 per person/$20,000.00 per occurrence).~~

~~____ I want Uninsured Motorist coverage in the following amount: $_____ per person/$_____ per occurrence.~~

~~____ I want to reject Uninsured Motorist coverage.~~

~~_____ _____~~

~~Proposed Insured~~

~~THIS FORM IS NOT A PART OF YOUR POLICY AND DOES NOT PROVIDE COVERAGE.~~

~~J. The Insurance Commissioner shall approve a deviation to the form described in subsection I of this section if the form includes substantially the same information.~~

~~K.~~ The following are effective on forms required on or after April 1, 2005. The offer of the coverage required by subsection B of this section shall be in the following form which shall be filed with and approved by the Insurance Commissioner. The form shall be provided to the proposed insured in writing separately from the application and shall read substantially as follows:

OKLAHOMA UNINSURED MOTORIST COVERAGE LAW

Oklahoma law gives you the right to buy Uninsured Motorist coverage in the same amount as your bodily injury liability coverage. THE LAW REQUIRES US TO ADVISE YOU OF THIS VALUABLE RIGHT FOR THE PROTECTION OF YOU, MEMBERS OF YOUR FAMILY, AND OTHER PEOPLE WHO MAY BE HURT WHILE RIDING IN YOUR INSURED VEHICLE. YOU SHOULD SERIOUSLY CONSIDER BUYING THIS COVERAGE IN THE SAME AMOUNT AS YOUR LIABILITY INSURANCE COVERAGE LIMIT.

Uninsured Motorist coverage, unless otherwise provided in your policy, pays for bodily injury damages to you, members of your family who live with you, and other people riding in your car who are injured by: (1) an uninsured motorist, (2) a hit-and-run motorist, or (3) an insured motorist who does not have enough

liability insurance to pay for bodily injury damages to any insured person. Uninsured Motorist coverage, unless otherwise provided in your policy, protects you and family members who live with you while riding in any vehicle or while a pedestrian. THE COST OF THIS COVERAGE IS SMALL COMPARED WITH THE BENEFITS!

You may make one of four choices about Uninsured Motorist Coverage:

1. You may buy Uninsured Motorist coverage equal to your bodily injury liability coverage for $_____ for _____ months.

2. You may buy Uninsured Motorist coverage in the amount of $25,000.00 for each person injured, not to exceed $50,000.00 for two or more persons injured in one occurrence (the smallest coverage which Oklahoma allows) for $_____ for _____ months.

3. You may buy Uninsured Motorist coverage in an amount less than your bodily injury liability coverage, but more than the minimum levels.

4. You may reject Uninsured Motorist coverage.

_____ I want the same amount of Uninsured Motorist coverage as my bodily injury liability coverage.

____ I want minimum Uninsured Motorist coverage $25,000.00 per person/$50,000.00 per occurrence.

____ I want Uninsured Motorist coverage in the following amount:

$_____ per person/$_____ per occurrence.

____ I want to reject Uninsured Motorist coverage.

_____

Proposed Insured

THIS FORM IS NOT A PART OF YOUR POLICY AND DOES NOT PROVIDE COVERAGE.

~~L.~~ J. The Insurance Commissioner shall approve a deviation from the form described in subsection ~~K~~ I of this section if the form includes substantially the same information.

~~M.~~ K. A change in the bodily injury liability coverage due to a change in the amount or limits prescribed for bodily injury or death by a policy meeting the requirements of Section 7-204 of Title 47 of the Oklahoma Statutes shall not be considered an amendment of the bodily injury liability coverage under paragraph 3 of subsection H of this section.

~~N.~~ L. On the first renewal on or after April 1, 2005, the insurer shall change the Uninsured Motorist coverage limits to $25,000.00 per person/$50,000.00 per occurrence and charge the corresponding premium for existing policyholders who have selected Uninsured Motorist coverage limits less than $25,000.00 per person/$50,000.00 per occurrence. At the first renewal on or after April 1, 2005, the insurer shall provide existing policyholders who have selected Uninsured Motorist coverage limits less than $25,000.00 per person/$50,000.00 per occurrence a notice of the change of their Uninsured Motorist coverage limits and that notice shall state how such policyholders may reject Uninsured Motorist

coverage limits or select Uninsured Motorist coverage with limits higher than $25,000.00 per person/$50,000.00 per occurrence. No notice shall be required to existing policyholders who have rejected Uninsured Motorist coverage or have selected Uninsured Motorist coverage limits equal to or greater than $25,000.00 per person/$50,000.00 per occurrence. For purposes of this subsection an existing policyholder is a policyholder who purchased a policy from the insurer before April 1, 2005, and such policy renews on or after April 1, 2005.

SECTION 32. AMENDATORY 36 O.S. 2001, Section 4430, as amended by Section 31, Chapter 307, O.S.L. 2002 (36 O.S. Supp. 2008, Section 4430), is amended to read as follows:

Section 4430. A. ~~1. An insurer may not charge a renewal premium rate for a long term care insurance policy which exceeds by more than fifteen percent (15%) any premium charged for the policy during the preceding twelve (12) months.~~

~~2.~~ Upon approval of the Insurance Commissioner, an insurer may charge ~~a~~ <u>an increased</u> renewal premium ~~exceeding the fifteen percent (15%) increase provided for in paragraph 1 of this subsection~~ upon showing that ~~a larger~~ <u>the</u> increase is necessary because of utilization of policy benefits in excess of the expected rate.

B. 1. This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

2. For certificates issued or delivered on or after November 1, 1995, under a group long-term care insurance policy as defined in Section 4424 of this title, which policy was in force on November 1, 1995, the provisions of this section shall not apply.

3. This section does not apply to policies or certificates approved for issue or delivery on or after November 1, 2001.

SECTION 33. AMENDATORY 36 O.S. 2001, Section 4509, is amended to read as follows:

Section 4509. A. When an insured employee or a dependent whose group insurance coverage is terminated and the coverage is subject to the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. 99-272, April 7, 1986, 100 Stat. 82, neither subsection B or C of this section applies.

B. In the case of an employee whose insurance is terminated under a group policy providing hospital, medical or surgical, or Christian Science care and treatment expense benefits~~,~~; or contract of hospital or medical service or indemnity; or prepaid health plan or health maintenance organization subscriber contract, such employee and ~~his~~ the dependents of the employee shall remain insured under the policy or contract for a period of at least ~~thirty (30)~~ sixty-three (63) days after such termination, unless during such period the employee and his dependents shall otherwise become entitled to similar insurance from some other source. Premiums may be charged for this period. The premiums charged shall be the

premiums which would have been charged for the coverage provided under the group policy or contract had termination not occurred.

C. If an employee has been covered for at least six (6) months under any group accident and health insurance policy delivered in this state, providing hospital, medical or surgical, or Christian Science care and treatment expense benefits, or under a contract of hospital or medical service or indemnity, and the individual employee has had his employment terminated or the group itself is terminated, then the termination shall not affect coverage of the insured or his dependents for any continuous loss which commenced while the insurance was in force. The extension of benefits beyond the period the insurance was in force may be predicated upon the continuous total disability of the person insured or his or her dependents or the expenses incurred in connection with a plan of surgical treatment, which shall include maternity care and delivery expenses, which commenced prior to the termination. The coverage for the extension of benefits shall be for the maximum benefits under the terminated policy or for a time period of not less than three (3) months in the case of basic coverage or six (6) months in the case of major medical coverage. Premium monies may be charged for the period of the extension of benefits. The premiums charged shall be the premiums which would have been charged for the coverage provided under the group policy or contract had termination not occurred.

SECTION 34. AMENDATORY Section 2, Chapter 276, O.S.L. 2002 (36 O.S. Supp. 2008, Section 4522), is amended to read as follows:

Section 4522. As used in the Employer Health Insurance Purchasing Group Act:

1. "Commissioner" means the Oklahoma Insurance Commissioner;

2. "Eligible employee" means an employee or individual who ~~is a~~ works the number of hours per week designated by the employer as full-time ~~employee of an eligible employer~~ employment and is qualified to enroll in a health benefit plan offered through a HIPG;

3. "Eligible employer" means an employer employing no more than one hundred eligible employees;

4. "Employer", "employee", and "dependent", unless otherwise defined in this section, shall have the meaning applied to the terms with respect to the coverage under the laws of the state relating to the coverage and the issuer;

5. "Full time" ~~means employees working at least twenty-four (24) hours per week for an eligible~~ shall be defined by the employer, but in no event shall it be less than twenty-four (24) hours per week;

6. "Health benefits plan" means a group plan, group policy, or group contract for health care services, issued or delivered by a HIPG health carrier, excluding plans, policies, or contracts

providing health care benefits or health care services pursuant to the Workers' Compensation Laws and mandatory liability laws;

7. "Health insurer" means any entity which provides health insurance in this state. For the purposes of the Employer Health Insurance Purchasing Group Act, "health insurer" includes a licensed insurance company, not-for-profit hospital service or medical indemnity corporation, or a health maintenance organization;

8. "HIPG" means a Health Insurance Purchasing Group meeting the requirements of this act;

9. "HIPG health carrier" means a health insurer as defined in this act;

10. "Large group" means a combination of two or more eligible employers belonging to a HIPG;

11. "Limited benefit contract" means, for the purposes of this act, a policy or certificate that does not contain state-mandated health benefits;

12. "Member" means an individual enrolled for health benefits coverage in a HIPG;

13. "Purchaser" means an eligible employer that has contracted with a HIPG for the purchase of health benefits coverage;

14. a. "State-mandated health benefits" means coverages 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 benefits 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 were mandated by federal law, and

b. "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; and

15. "Total eligible employees" means two hundred or more eligible employees.

SECTION 35. AMENDATORY 36 O.S. 2001, Section 5002, as amended by Section 21, Chapter 184, O.S.L. 2008 (36 O.S. Supp. 2008, Section 5002), is amended to read as follows:

Section 5002. A. A domestic title insurer shall invest its capital accumulations, up to the sum of One Hundred Thousand Dollars

($100,000.00), in capital investments as defined in Section 1606 of Article 16 (Investments), but subject to the exception in subsection B of this section, below.

B. A domestic title insurer may invest its capital and accumulations in excess of One Hundred Thousand Dollars ($100,000.00) in such investments as are made eligible for funds of domestic insurers by Article 16; except, that any such insurer may invest an amount not exceeding fifty percent (50%) of its combined capital and surplus in the preparation and purchase of material or plants or both necessary to enable it to engage in the business of title insurance, and such materials and plants shall be deemed to be capital funds investments and shall be valued as the actual cost thereof.

C. ~~Section 1606 of Article 16 shall not apply to domestic~~ Domestic title insurers~~, nor~~ shall ~~such insurers~~ not be subject to the limitations as to amount invested in real estate for home office and branch office purposes contained in paragraph 1 of Section 1624 of Article 16.

SECTION 36. AMENDATORY 36 O.S. 2001, Section 6055, as amended by Section 2, Chapter 288, O.S.L. 2003 (36 O.S. Supp. 2008, Section 6055), is amended to read as follows:

Section 6055. A. Under any accident and health insurance policy, hereafter renewed or issued for delivery from out of Oklahoma or in Oklahoma by any insurer and covering an Oklahoma

risk, the services and procedures may be performed by any practitioner selected by the insured, or the parent or guardian of the insured if the insured is a minor, if the services and procedures fall within the licensed scope of practice of the practitioner providing the same.

B. An accident and health insurance policy may:

1. Exclude or limit coverage for a particular illness, disease, injury or condition; but, except for such exclusions or limits, shall not exclude or limit particular services or procedures that can be provided for the diagnosis and treatment of a covered illness, disease, injury or condition, if such exclusion or limitation has the effect of discriminating against a particular class of practitioner. However, such services and procedures, in order to be a covered medical expense, must:

a. be medically necessary,

b. be of proven efficacy, and

c. fall within the licensed scope of practice of the practitioner providing same; and

2. Provide for the application of deductibles and copayment provisions, when equally applied to all covered charges for services and procedures that can be provided by any practitioner for the diagnosis and treatment of a covered illness, disease, injury or condition. ~~This provision~~

C. 1. Paragraph 2 of subsection B of this section shall not be construed to prohibit differences in cost-sharing provisions such as deductibles and copayment provisions between practitioners, hospitals and ambulatory surgical centers who are participating preferred provider organization providers and practitioners, hospitals and ambulatory surgical centers who are not participating in the preferred provider organization, subject to the following limitations:

a. the amount of any annual deductible per covered person or per family for treatment in a hospital or ambulatory surgical center that is not a preferred provider shall not exceed three times the amount of a corresponding annual deductible for treatment in a hospital or ambulatory surgical center that is a preferred provider,

b. if the policy has no deductible for treatment in a preferred provider hospital or ambulatory surgical center, the deductible for treatment in a hospital or ambulatory surgical center that is not a preferred provider shall not exceed One Thousand Dollars ($1,000.00) per covered-person visit,

c. the amount of any annual deductible per covered person or per family treatment, other than inpatient treatment, by a practitioner that is not a preferred

practitioner shall not exceed three times the amount of a corresponding annual deductible for treatment, other than inpatient treatment, by a preferred practitioner,

d. if the policy has no deductible for treatment by a preferred practitioner, the annual deductible for treatment received from a practitioner that is not a preferred practitioner shall not exceed Five Hundred Dollars ($500.00) per covered person,

e. the percentage amount of any coinsurance to be paid by an insured to a practitioner, hospital or ambulatory surgical center that is not a preferred provider shall not exceed by more than thirty (30) percentage points the percentage amount of any coinsurance payment to be paid to a preferred provider~~,~~.

~~f. a~~

2. The Commissioner has discretion to approve a cost-sharing arrangement which does not satisfy the limitations imposed by this subsection if the Commissioner finds that such cost-sharing arrangement will provide a reduction in premium costs.

D. 1. A practitioner, hospital or ambulatory surgical center that is not a preferred provider shall disclose to the insured, in writing, that the insured may be responsible for:

~~(1)~~

a. higher coinsurance and deductibles, and

~~(2)~~

b. practitioner, hospital or ambulatory surgical center charges which exceed the allowable charges of a preferred provider~~, and~~.

~~g.~~ ~~when~~

2. When a referral is made to a nonparticipating hospital or ambulatory surgical center, the referring practitioner must disclose in writing to the insured, any ownership interest in the nonparticipating hospital or ambulatory surgical center.

~~C.~~ E. Upon submission of a claim by a practitioner, hospital, home care agency, or ambulatory surgical center to an insurer on a uniform health care claim form adopted by the Insurance Commissioner pursuant to Section 6581 of this title, the insurer shall provide a timely explanation of benefits to the practitioner, hospital, home care agency, or ambulatory surgical center regardless of the network participation status of such person or entity.

~~D.~~ F. Benefits available under an accident and health insurance policy, at the option of the insured, shall be assignable to a practitioner, hospital, home care agency or ambulatory surgical center who has provided services and procedures which are covered under the policy. A practitioner, hospital, home care agency or ambulatory surgical center shall be compensated directly by an

insurer for services and procedures which have been provided when the following conditions are met:

1. Benefits available under a policy have been assigned in writing by an insured to the practitioner, hospital, home care agency or ambulatory surgical center;

2. A copy of the assignment has been provided by the practitioner, hospital, home care agency or ambulatory surgical center to the insurer;

3. A claim has been submitted by the practitioner, hospital, home care agency or ambulatory surgical center to the insurer on a uniform health insurance claim form adopted by the Insurance Commissioner pursuant to Section 6581 of this title; and

4. A copy of the claim has been provided by the practitioner, hospital, home care agency or ambulatory surgical center to the insured.

~~E.~~ G. The provisions of subsection D of this section shall not apply to:

1. Any preferred provider organization (PPO) as defined by generally accepted industry standards, that contracts with practitioners that agree to accept the reimbursement available under the PPO agreement as payment in full and agree not to balance bill the insured; or

2. Any statewide provider network which:

a. provides that a practitioner, hospital, home care agency or ambulatory surgical center who joins the provider network shall be compensated directly by the insurer,

b. does not have any terms or conditions which have the effect of discriminating against a particular class of practitioner,

c. allows any practitioner, hospital, home care agency or ambulatory surgical center, except a practitioner who has a prior felony conviction, to become a network provider if said hospital or practitioner is willing to comply with the terms and conditions of a standard network provider contract, and

d. contracts with practitioners that agree to accept the reimbursement available under the network agreement as payment in full and agree not to balance bill the insured.

~~F.~~ H. A nonparticipating practitioner, hospital or ambulatory surgical center may request from an insurer and the insurer shall supply a good-faith estimate of the allowable fee for a procedure to be performed upon an insured based upon information regarding the anticipated medical needs of the insured provided to the insurer by the nonparticipating practitioner.

~~G.~~ I. A practitioner shall be equally compensated for covered services and procedures provided to an insured on the basis of charges prevailing in the same geographical area or in similar sized communities for similar services and procedures provided to similarly ill or injured persons regardless of the branch of the healing arts to which the practitioner may belong, if:

1. The practitioner does not authorize or permit false and fraudulent advertising regarding the services and procedures provided by the practitioner; and

2. The practitioner does not aid or abet the insured to violate the terms of the policy.

~~H.~~ J. Nothing in the Health Care Freedom of Choice Act shall prohibit an insurer from establishing a preferred provider organization and a standard participating provider contract therefor, specifying the terms and conditions, including, but not limited to, provider qualifications, and alternative levels or methods of payment that must be met by a practitioner selected by the insurer as a participating preferred provider organization provider.

~~I.~~ K. A preferred provider organization, in executing a contract, shall not, by the terms and conditions of the contract or internal protocol, discriminate within its network of practitioners with respect to participation and reimbursement as it relates to any

practitioner who is acting within the scope of the practitioner's license under the law solely on the basis of such license.

~~J.~~ L. Decisions by an insurer or a preferred provider organization (PPO) to authorize or deny coverage for an emergency service shall be based on the patient presenting symptoms arising from any injury, illness, or condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a reasonable and prudent layperson could expect the absence of medical attention to result in serious:

1. Jeopardy to the health of the patient;

2. Impairment of bodily function; or

3. Dysfunction of any bodily organ or part.

~~K.~~ M. An insurer or preferred provider organization (PPO) shall not deny an otherwise covered emergency service based solely upon lack of notification to the insurer or PPO.

~~L.~~ N. An insurer or a preferred provider organization (PPO) shall compensate a provider for patient screening, evaluation, and examination services that are reasonably calculated to assist the provider in determining whether the condition of the patient requires emergency service. If the provider determines that the patient does not require emergency service, coverage for services rendered subsequent to that determination shall be governed by the policy or PPO contract.

~~M.~~ O. Nothing in this act shall be construed as prohibiting an insurer, preferred provider organization or other network from determining the adequacy of the size of its network.

SECTION 37. AMENDATORY 36 O.S. 2001, Section 6103.2, is amended to read as follows:

Section 6103.2 A. Unless otherwise indicated, the term "insurer" as used in Sections 6103.1 through 6103.11 of this title includes all legal entities, associations, and individuals engaged as principals in the business of insurance and also includes interinsurance exchanges, mutual benefit societies and insurance exchanges and syndicates.

B. The venue of any act listed in this section shall be Oklahoma County.

C. Any one of the following acts in this state effected by mail or otherwise is defined to be doing an insurance business in this state:

1. The making of or proposing to make, as an insurer, an insurance contract;

2. The making of or proposing to make, as guarantor or surety, any contract of guaranty or suretyship as a vocation and not merely incidental to any other legitimate business or activity of the guarantor or surety;

3. The taking or receiving of any application for insurance;

4. Maintaining any agency or office where any acts in furtherance of an insurance business are transacted, including but not limited to:

a. the execution of contracts of insurance with citizens of this or any other state,

b. maintaining files or records of contracts of insurance,

c. the processing of claims, and

d. the receiving or collection of any premiums, commissions, membership fees, assessments, dues or other consideration for any insurance or any part thereof;

5. The issuance or delivery of contracts of insurance to residents of this state or to persons authorized to do business in this state;

6. Directly or indirectly acting as an agent for, or otherwise representing or aiding on behalf of another, any person or insurer in:

a. the solicitation, negotiation, procurement or effectuation of insurance or renewals thereof,

b. the dissemination of information as to coverage or rates, or forwarding of applications, or delivery of policies or contracts,

c. inspection of risks,

d. fixing of rates or investigation or adjustment of claims or losses,

e. the transaction of matters subsequent to effectuation of the contract and arising out of it, or

f. in any other manner representing or assisting a person or insurer in the transaction of insurance with respect to subjects of insurance resident, located or to be performed in this state;

Provided, the provisions of this paragraph shall not operate to prohibit full-time salaried employees of a corporate insured from acting in the capacity of an insurance manager or buyer in placing insurance in behalf of such employer;

7. Contracting to provide indemnification or expense reimbursement in this state to persons domiciled in this state or for risks located in this state, whether as an insurer, agent, administrator, trust, funding mechanism, or by any other method, for any type of medical expenses including, but not limited to, surgical, chiropractic, physical therapy, speech pathology, audiology, professional mental health, dental, hospital, or optometric expenses, whether this coverage is by direct payment, reimbursement, or otherwise. This provision shall not apply to:

a. any program otherwise authorized by law that is established by any political subdivision of this state

or under the provisions of Sections 1001 through 1008 of Title 74 of the Oklahoma Statutes, or

b. a multiple employer welfare arrangement as defined in Section 3 of the Employee Retirement Income Security Act of 1974, 29 U.S.C., Section 1002(40)(A), as amended, that holds a valid license issued by the Insurance Commissioner or is exempt from state regulation pursuant to subsection B of Section 634 of this title;

8. The doing of any kind of insurance business specifically recognized as constituting the doing of an insurance business within the meaning of the statutes relating to insurance;

9. The doing or proposing to do any insurance business in substance equivalent to any of the foregoing in a manner designed to evade the provisions of the statutes; or

10. Any other transactions of business in this state by an insurer.

D. <u>The definition of a bail bond shall be the same as the definition of a bond in Section 1301 of Title 59 of the Oklahoma Statutes. The business of bail bonds shall be all aspects of acting as a bail bondsman including, but not limited to, depositing or pledging cash or real property as security for an appearance bond in a criminal judicial proceeding, or executing or countersigning bail bonds for an insurer or professional bondsman in connection with an</u>

appearance bond in criminal judicial proceedings, and charging and receiving money for these services. The business of bail bonds shall also include solicitation for a bail bond, as defined in Section 1301 of Title 59 of the Oklahoma Statutes.

E. The provisions of this section do not apply to:

1. The lawful transaction of surplus lines insurance;

2. Life, accident and health insurance or annuities provided to educational or scientific institutions organized and operated without profit to any private shareholder or individual for the benefit of such institutions or individuals engaged in the service of such institutions;

3. The lawful transaction of reinsurance by insurers; ~~or~~

4. Transactions in this state involving a policy lawfully solicited, written and delivered outside of this state covering only subjects of insurance not resident, located or expressly to be performed in this state at the time of issuance, and which transactions are subsequent to the issuance of such policy; or

5. Any individual who is not required to have a bail bondsman license, as provided in Section 1303 of Title 59 of the Oklahoma Statutes.

SECTION 38. AMENDATORY 36 O.S. 2001, Section 6103.3, is amended to read as follows:

Section 6103.3 A. For the purposes of Sections 6103.1 through 6103.11 of this title, "person" shall include an individual, a

partnership, a corporation, a limited liability company, an association, a joint stock company, a trust, an unincorporated organization, any similar group, entity or any combination of the foregoing acting in concert.

B. No person or insurer shall directly or indirectly do any of the acts of an insurance business set forth in Sections 6103.1 through 6103.11 of this title, except as provided by and in accordance with the specific authorization of statute. In respect to the insurance of subjects resident, located or to be performed within this state, this section shall not prohibit the collection of premium or other acts performed outside of this state by persons or insurers authorized to do business in this state provided such transactions and insurance contracts otherwise comply with statute.

C. Any person which the Insurance Commissioner has reason to believe is doing any of the acts specified in Section 6103.2 of this title, upon written request by the Commissioner, shall immediately provide to the Commissioner such information as requested in relation to such acts.

D. A person or entity who violates any provision of Sections 6103.1 through 6103.11 of this title is subject to a civil penalty of not more than Ten Thousand Dollars ($10,000.00) for each act of violation and for each day of violation to be recovered as provided in this section.

E. Whenever the Commissioner has reason to believe or it appears that any person or insurer has violated or is threatening to violate any provision of Sections 6103.1 through 6103.11 of this title or any rule promulgated pursuant thereto, or that any person or insurer acting in violation of Sections 6103.1 through 6103.11 of this title has engaged in or is threatening to engage in any unfair method of competition or any unfair or deceptive act or practice as defined by Section 1201 et seq. of this title or any rule promulgated pursuant thereto, the Commissioner may:

1. Issue an ex parte cease and desist order under the procedures provided by Sections 6103.5 and 6103.6 of this title;

2. Institute in the district court of Oklahoma County a civil suit for injunctive relief to restrain the person from continuing the violation or threat of violation;

3. Institute in the district court of Oklahoma County a civil suit to recover a civil penalty as provided for in this section; or

4. Exercise any combination of the acts provided for in this subsection.

F. On application for injunctive relief and a finding that a person is violating or threatening to violate any provision of Sections 6103.1 through 6103.11 of this title, the district court shall grant the injunctive relief and the injunction shall be issued without bond.

G. The remedies provided in Sections 6103.1 through 6103.11 of this title for administrative action against unauthorized insurers shall also apply to unauthorized individuals or persons engaged in the business of bail bonds.

H. This section shall not be construed to limit the Insurance Commissioner to the remedies specified herein. It is the intent of the Legislature that persons engaging in the business of insurance without statutory authorization constitute an imminent peril to the public welfare and should immediately be stopped and enjoined from doing so, provided, the Insurance Commissioner and the State of Oklahoma should be able to choose at any time any available remedy or action to bring about such a result without regard to prior proceedings under this section.

SECTION 39. AMENDATORY 36 O.S. 2001, Section 6103.5, is amended to read as follows:

Section 6103.5 The Insurance Commissioner may issue a cease and desist order, ex parte, if:

1. The Commissioner believes:

a. an unauthorized person is engaging in the business of insurance in violation of Section 6103.2 of this title or in violation of a rule promulgated pursuant to Sections 6103.1 through 6103.11 of this title, or

b. an unauthorized person engaged in the business of insurance acting in violation of Section 6103.3 of

this title is committing an unfair method of competition or an unfair or deceptive act or practice in violation of Section 1201 et seq. of this title or in violation of any rule promulgated pursuant thereto~~;~~, or

c. an unauthorized person or individual is engaging in the business of bail bonds in violation of Section 6103.2 of this title or in violation of a rule promulgated pursuant to Sections 6103.1 through 6103.11 of this title; or

2. It appears to the Commissioner that the alleged conduct is fraudulent or hazardous or creates an immediate danger to the public safety or is causing or can be reasonably expected to cause significant, imminent and irreparable public injury.

SECTION 40. AMENDATORY 36 O.S. 2001, Section 6203, is amended to read as follows:

Section 6203. For the purpose of the Insurance Adjusters Licensing Act, no one shall be deemed to be an adjuster or be required to obtain a license as an adjuster who is:

1. A licensed agent or general agent of an insurer who processes undisputed or uncontested losses for said insurers solely pursuant to the provisions of policies issued by the agent, or his agency, if the agent or general agent receives no extra compensation for such services; or

2. Engaged in investigating, adjusting, negotiating, or processing claims arising pursuant to the provisions of life insurance, annuity, or accident and health insurance contracts; or

3. A nonresident who occasionally is in this state to adjust a single loss or losses arising pursuant to the provisions of a policy of marine insurance; or

4. A salaried employee of a licensed insurer whose primary duties are not adjusting, investigating, or supervising insurance claims; or

5. A licensed attorney in the State of Oklahoma who adjusts insurance losses from time to time, incidental to the practice of law, and who does not advertise or represent that he is an adjuster; or

6. A person employed solely for the purpose of furnishing technical assistance to a licensed adjuster, including but not limited to photographers, appraisers, estimators, private detectives, engineers, handwriting experts, and attorneys-at-law; or

7. A person who performs clerical duties for a licensed insurer or organization that handles claims and who does not negotiate disputed or contested claims for the insurer or organization that handles claims; or

8. A nonresident insurance adjuster ~~whose resident state has a reciprocal agreement with the State of Oklahoma~~ <u>who is actively licensed in another state</u> and who is in this state no more than once

a year for the purpose of adjusting a single loss or losses arising out of an occurrence common to all such losses, or who is acting as a temporary substitute for a licensed adjuster.

SECTION 41. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6204.1 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The apprentice adjuster license is an optional license to facilitate the experience, education, and training necessary to ensure reasonable competency of the responsibilities and duties of an adjuster.

B. An individual applying for a resident apprentice adjuster license shall make application to the Insurance Commissioner on the appropriate NAIC Uniform Individual Application or an application approved by the Commissioner in a format prescribed by the Commissioner and declare under penalty of suspension, revocation, or refusal of the license that the statements made in the application are true, correct, and complete to the best of the knowledge and belief of the individual. Before approving the application, the Insurance Commissioner shall find that the individual:

1. Is at least eighteen (18) years of age;

2. Is a resident of this state and has designated this state as the home state of the individual;

3. Has a business or mailing address in this state for acceptance of service of process;

4. Has not committed any act that is a ground for probation, suspension, revocation, or denial of licensure as set forth in Section 6220 of Title 36 of the Oklahoma Statutes;

5. Is trustworthy, reliable, and of good reputation, evidence of which may be determined by the Insurance Commissioner; and

6. Has paid the fees set forth in Section 6212 of Title 36 of the Oklahoma Statutes.

C. The apprentice adjuster license shall be subject to the following terms and conditions:

1. Accompanying the apprentice application shall be an attestation, from a licensed adjuster with the same line or lines of authority for which the apprentice has applied, certifying that the apprentice will be subject to training, direction, and control by the licensed adjuster and further certifying that the licensed adjuster assumes responsibility for the actions of the apprentice in the apprentice's capacity as an adjuster;

2. The apprentice adjuster is authorized to adjust claims only in this state;

3. The apprentice licensee is restricted to participation in the investigation, settlement, and negotiation of claims subject to the review and final determination of the claim by the supervising licensed adjuster;

4. Compensation of an apprentice adjuster shall be on a salaried or hourly basis only;

5. The apprentice adjuster shall not be required to take and successfully complete the adjuster examination pursuant to Section 6208 of Title 36 of the Oklahoma Statutes, to adjust claims as an apprentice adjuster. However, at any time during the apprenticeship the apprentice adjuster may choose to take the examination. If the individual takes and successfully completes the adjuster exam, the apprentice adjuster license shall automatically terminate and an adjuster license shall be issued to that individual;

6. The apprentice adjuster license is for a period not to exceed six (6) months and is nonrenewable; and

7. The licensee shall be subject to probation, suspension, revocation, or refusal pursuant to Section 6220 of Title 36 of the Oklahoma Statutes.

D. The licensed adjuster responsible for the apprentice adjuster, as stated in paragraph 1 of subsection C of this section, shall supervise no more than five active apprentice licensees at any given time.

SECTION 42. AMENDATORY 36 O.S. 2001, Section 6205, as amended by Section 24, Chapter 125, O.S.L. 2007 (36 O.S. Supp. 2008, Section 6205), is amended to read as follows:

Section 6205. A. Application for a license as an adjuster shall be made to the Insurance Commissioner upon forms prescribed and furnished by the Commissioner. As a part of and in connection with the application, the applicant shall furnish such information

concerning the applicant's identity, personal history, business experience, business record and such other pertinent information which the Commissioner shall reasonably require.

B. Unless denied licensure pursuant to Section 6220 of this title, a nonresident applicant shall receive a nonresident adjuster license if:

1. The applicant has passed an examination in the applicant's home state;

2. The applicant is currently licensed and in good standing in the home state of the applicant;

3. The applicant has submitted the proper request for licensure and has paid the fees required by Section 6212 of this title; and

4. The applicant's home state awards nonresident adjuster licenses to residents of this state on the same basis.

C. If a nonresident applicant's home state does not license or require an examination for an adjuster license, ~~the applicant shall pass an examination in this state prior to receiving a nonresident adjuster license~~ the adjuster may declare another state which has an examination requirement and in which the adjuster is licensed to be the home state. Should the applicant not hold an active adjuster license in his or her home state or declared home state, the applicant shall pass the adjuster examination of this state prior to receiving a nonresident adjuster license.

SECTION 43. AMENDATORY 36 O.S. 2001, Section 6206, as amended by Section 25, Chapter 125, O.S.L. 2007 (36 O.S. Supp. 2008, Section 6206), is amended to read as follows:

Section 6206. A. The Insurance Commissioner shall license as an adjuster only an individual who has fully complied with the provisions of the Insurance Adjusters Licensing Act, including the furnishing of evidence satisfactory to the Commissioner that the applicant:

1. Is at least eighteen (18) years of age;

2. Is a bona fide resident of this state or is a resident of a state or country which permits adjusters who are residents of this state to act as adjusters in such other state or country;

3. If a nonresident of the United States, has complied with all federal laws pertaining to employment and the transaction of business in the United States;

4. Is a trustworthy person;

5. Has had experience or special education or training of sufficient duration and extent with reference to the handling of loss claims pursuant to insurance contracts to make the applicant competent to fulfill the responsibilities of an adjuster;

6. Has successfully passed an examination as required by the Commissioner or has been exempted from examination, in accordance with the provisions of Section 6208 of this title; and

7. If the application is for a public adjuster's license, the applicant has filed the bond required by Section 6214 of this title.

B. Residence addresses and telephone listings, birth dates, and social security numbers for insurance adjusters and public adjusters on file with the Insurance Department are exempt from disclosure as public records. A separate business or mailing address as provided by the adjuster shall be considered a public record and upon request shall be disclosed. If an adjuster's residence and business address or residence and business telephone number are the same, such address or telephone number shall be considered a public record.

C. The mailing address shall appear on all licenses of the licensee, and the licensee shall promptly notify the Insurance Commissioner within thirty (30) days of any change in ~~the~~ legal name or mailing, business or residence address of the licensee. A change in legal name or address thirty (30) days after the change must include an administrative fee of Fifty Dollars ($50.00). Failure to provide acceptable notification of a change of legal name or address to the Insurance Commissioner within forty-five (45) days of the date the administrative fee is assessed will result in penalties pursuant to Section 6220 of this title.

SECTION 44. AMENDATORY 36 O.S. 2001, Section 6208, as amended by Section 26, Chapter 125, O.S.L. 2007 (36 O.S. Supp. 2008, Section 6208), is amended to read as follows:

Section 6208. A. Each applicant for a license as an adjuster shall, prior to issuance of said license, personally take and pass, to the satisfaction of the Commissioner, an examination ~~given~~ approved by the Commissioner as a test of the qualifications and competency of the applicant.

B. The requirement of an examination shall not apply to the following:

1. An applicant who is licensed as an adjuster in this state during the ninety-day period preceding November 1, 1983; or

2. A nonresident applicant who has passed an examination in the home state of the applicant and who is currently licensed and in good standing in the applicant's home state; or

3. Any applicant for a license covering the same class or classes of insurance for which the applicant was licensed in this state pursuant to a similar license during the twenty-four-month period immediately preceding the date of application, unless said previous license was revoked or suspended, or continuation of the license was refused by the Commissioner; or

4. An applicant for a resident license who has passed an examination in the former home state and who is licensed and in good standing in the former home state at the time the application is submitted. The applicant shall make application to become a resident adjuster within ninety (90) days after establishing legal residence in Oklahoma.

SECTION 45. AMENDATORY 36 O.S. 2001, Section 6209, is amended to read as follows:

Section 6209. A. Each examination for a license as an adjuster shall be prescribed by the Commissioner and shall be of sufficient scope to reasonably test the knowledge of the applicant as to the kinds of insurance contracts which may be dealt with in accordance with the license applied for, the duties and responsibilities of insurers pursuant to said contracts and pursuant to the laws of this state applicable to the adjusting claims of losses in accordance with the license applied for.

B. An applicant for a license as an adjuster may qualify in any one of the following classes of insurance or combinations thereof, and the license when issued may be limited to cover adjusting in any one of the following classes of insurance or combinations thereof. The application for a license shall specify which of the following classes of business the application and license are to cover:

1. motor vehicle physical damage, meaning damages to all land motor vehicles and trailers whether or not covered by first party physical damage coverages or property damage liability coverages; or

2. fire and allied lines, including marine, inland marine, and aircraft; or

3. casualty, meaning all lines of liability insurance coverages for bodily injuries, personal injury, and property damages; or

4. workers' compensation; or

5. crime and fidelity bonds; or

6. crop/hail.

C. The Commissioner shall prepare and make available to applicants a manual of instructions stating in general terms the subjects which may be covered in any examination for a license as an adjuster. The Commissioner may charge a reasonable amount not to exceed ~~Twenty five Dollars ($25.00)~~ Forty Dollars ($40.00) for the study manual.

SECTION 46. AMENDATORY 36 O.S. 2001, Section 6210, as last amended by Section 24, Chapter 184, O.S.L. 2008 (36 O.S. Supp. 2008, Section 6210), is amended to read as follows:

Section 6210. A. The answers of the applicant to any examination for licensing as an adjuster shall be written by the applicant under supervision of the Insurance Commissioner or an administrator approved by the Insurance Commissioner.

B. ~~The examination shall be given at such times and places within this state as the Commissioner deems necessary to reasonably serve the convenience of both the Commissioner and the applicants~~ Examination for licensing shall be at such reasonable times and places as are designated by the Insurance Commissioner.

C. An applicant who has failed to pass the first examination for the license for which applied may take a second examination within thirty (30) days following the first examination. An

applicant who has failed to pass the first two examinations for the license for which applied shall not be permitted to take a subsequent examination until the expiration of thirty (30) days after the last previous examination. An applicant shall take and pass the examination within one hundred eighty (180) days of the date of the initial application. If the applicant fails to pass an examination within the specified time period, the applicant shall submit a new application accompanied by any applicable fees. Examination fees for subsequent examinations shall not be waived.

SECTION 47. AMENDATORY 36 O.S. 2001, Section 6212, is amended to read as follows:

Section 6212. A. The Insurance Commissioner or an administrator approved by the Insurance Commissioner shall collect a fee of Twenty Dollars ($20.00) for an examination for an adjuster's license in any of the following single classes of business. The fee for any ~~combination of two or more examinations~~ examination which includes two or more classes of business shall not exceed Forty Dollars ($40.00). The classes of business are:

1. Motor vehicle physical damage;
2. Fire and allied lines (property);
3. Casualty;
4. Workers' compensation;
5. Crime and fidelity bonds; and
6. Crop/hail.

B. The Commissioner shall collect the following fees for an adjuster's license:

1. For a license in any single class of business, every two (2) years, Thirty Dollars ($30.00);

2. For a license in any combination of two or more classes of business, every two years, Fifty Dollars ($50.00);

3. Public adjuster, every two years, Thirty Dollars ($30.00); ~~and~~

4. Emergency adjuster, as provided for in Section 6218 of this title, each year, Fifteen Dollars ($15.00); and

5. Apprentice adjuster, as provided for in Section 6204.1 of this title, Twenty Dollars ($20.00).

C. The fees prescribed in this section ~~for examinations~~ shall accompany the application for an original license or a renewal of a license.

D. The fee for the original license or renewal license shall be collected in advance of issuance. Late application for renewal shall require a fee of double the amount of the original license fee.

E. The Commissioner may issue a duplicate license for any lost, stolen, or destroyed license issued pursuant to the provisions of the Insurance Adjusters Licensing Act if an affidavit is submitted by the licensee to the Commissioner concerning the facts of such loss, theft, or destruction. Said affidavit shall be in a form

prescribed by the Commissioner. The fee for a duplicate license shall be ~~Five Dollars ($5.00)~~ one-half (1/2) the fee of the license.

F. The administrative fee for submission of a change of legal name or address more than thirty (30) days after the change occurred shall be Fifty Dollars ($50.00).

SECTION 48. AMENDATORY 36 O.S. 2001, Section 6217, as last amended by Section 25, Chapter 184, O.S.L. 2008 (36 O.S. Supp. 2008, Section 6217), is amended to read as follows:

Section 6217. A. ~~A license as an adjuster shall expire two (2) years from the month of original issuance of the license or subsequent renewal of the license~~ All licenses issued pursuant to the provisions of the Insurance Adjusters Licensing Act shall continue in force not longer than twenty-four (24) months. The renewal dates for the licenses may be staggered throughout the year by notifying licensees in writing of the expiration and renewal date being assigned to the licensees by the Insurance Commissioner and by making appropriate adjustments in the biennial licensing fee.

B. Any licensee applying for renewal of a license as an adjuster shall have completed not less than ~~twelve (12)~~ twenty-four (24) clock hours of continuing insurance education, of which three (3) hours must be in ethics, within the previous twenty-four (24) months prior to renewal of the license. Such continuing education shall cover subjects in the classes of insurance for which the adjuster is licensed. ~~Such continuing education shall not include a~~

~~written or oral examination.~~ The Insurance Commissioner shall approve courses and providers of continuing education for insurance adjusters as required by this section.

The Insurance Department may use one or more of the following to review and provide a nonbinding recommendation to the Insurance Commissioner on approval or disapproval of courses and providers of continuing education:

1. Employees of the Insurance Commissioner;

2. A continuing education advisory committee. The continuing education advisory committee is separate and distinct from the Advisory Board established by Section 6221 of this title;

3. An independent service whose normal business activities include the review and approval of continuing education courses and providers. The Commissioner may negotiate agreements with such independent service to review documents and other materials submitted for approval of courses and providers and present the Commissioner with its nonbinding recommendation. The Commissioner may require such independent service to collect the fee charged by the independent service for reviewing materials provided for review directly from the course providers.

C. An adjuster who, during the time period prior to renewal, participates in an approved professional designation program shall be deemed to have met the biennial requirement for continuing education. Each course in the curriculum for the program shall

total a minimum of twenty (20) hours. Each approved professional designation program included in this section shall be reviewed for quality and compliance every three (3) years in accordance with standardized criteria promulgated by rule. Continuation of approved status is contingent upon the findings of the review. The list of professional designation programs approved under this subsection shall be made available to producers and providers annually.

D. The Insurance Department may promulgate rules providing that courses or programs offered by professional associations shall qualify for presumptive continuing education credit approval. The rules shall include standardized criteria for reviewing the professional associations' mission, membership, and other relevant information, and shall provide a procedure for the Department to disallow a presumptively approved course. Professional association courses approved in accordance with this subsection shall be reviewed every three (3) years to determine whether they continue to qualify for continuing education credit.

E. The active service of a licensed adjuster as a member of a continuing education advisory committee, as described in paragraph 2 of subsection B of this section, shall be deemed to qualify for continuing education credit on an hour-for-hour basis.

F. Each provider of continuing education shall, after approval by the Commissioner, submit an annual fee. A fee may be assessed for each course submission at the time it is first submitted for

review and upon submission for renewal at expiration. Annual fees and course submission fees shall be set forth as a rule by the Commissioner. The fees are payable to the Insurance Commissioner and shall be deposited in the State Insurance Commissioner Revolving Fund, created in subsection C of Section 1435.23 of this title, for the purposes of fulfilling and accomplishing the conditions and purposes of the Oklahoma Producer Licensing Act and the Insurance Adjusters Licensing Act. Public-funded educational institutions, federal agencies, nonprofit organizations, not-for-profit organizations and Oklahoma state agencies shall be exempt from this subsection.

G. Subject to the right of the Commissioner to suspend, revoke, or refuse to renew a license of an adjuster, any such license may be renewed by filing on the form prescribed by the Commissioner on or before the expiration date a written request by or on behalf of the licensee for such renewal and proof of completion of the continuing education requirement set forth in subsection B of this section, accompanied by payment of the renewal fee.

H. If the request, proof of compliance with the continuing education requirement and fee for renewal of a license as an adjuster are filed with the Commissioner prior to the expiration of the existing license, the licensee may continue to act pursuant to said license, unless revoked or suspended prior to the expiration date, until the issuance of a renewal license or until the

expiration of ten (10) days after the Commissioner has refused to renew the license and has mailed notice of said refusal to the licensee. Any request for renewal filed after the date of expiration may be considered by the Commissioner as an application for a new license.

SECTION 49. AMENDATORY Section 18, Chapter 334, O.S.L. 2004 (36 O.S. Supp. 2008, Section 6470.11), is amended to read as follows:

Section 6470.11 A. A captive insurance company may not be required to make an annual report except as provided in the Oklahoma Captive Insurance Company Act.

B. Before March 1 of each year, a captive insurance company or a captive reinsurance company shall submit to the Insurance Commissioner a report of its financial condition, verified by oath of two of its executive officers. Except as provided in Sections ~~13~~ 6470.6 and ~~15~~ 6470.8 of this ~~act~~ title, a captive insurance company or a captive reinsurance company shall report using ~~generally accepted~~ statutory accounting principles, unless the Insurance Commissioner approves the use of ~~statutory~~ generally accepted accounting principles, with useful or necessary modifications or adaptations required or approved or accepted by the Insurance Commissioner for the type of insurance and kinds of insurers to be reported upon, and as supplemented by additional information required by the Insurance Commissioner. Except as otherwise

provided, an association captive insurance company and an industrial insured group shall file their report in the form required by the Insurance Commissioner, and each industrial insured group shall comply with the requirements set forth in the Oklahoma Insurance Code. The Insurance Commissioner by regulation shall prescribe the forms in which pure captive insurance companies and industrial insured captive insurance companies shall report.

C. A pure captive insurance company may make written application for filing the required report on a fiscal year-end that is consistent with the fiscal year of the parent company. If an alternative reporting date is granted:

1. The annual report is due sixty (60) days after the fiscal year-end; and

2. In order to provide sufficient detail to support the premium tax return, the pure captive insurance company shall file before March 1 of each year for each calendar year-end, pages 1 through 7 of the "Captive Annual Statement: Pure or Industrial Insured", verified by oath of two of its executive officers.

D. Sixty (60) days after the fiscal year-end, a branch captive insurance company shall file with the Insurance Commissioner a copy of all reports and statements required to be filed under the laws of the jurisdiction in which the alien captive insurance company is formed, verified by oath of two of its executive officers. If the Insurance Commissioner is satisfied that the annual report filed by

the alien captive insurance company in its domiciliary jurisdiction provides adequate information concerning the financial condition of the alien captive insurance company, the Insurance Commissioner may waive the requirement for completion of the captive annual statement for business written in the alien jurisdiction. Such waiver must be in writing and subject to public inspection.

SECTION 50. AMENDATORY 36 O.S. 2001, Section 6512, is amended to read as follows:

Section 6512. As used in the Small Employer Health Insurance Reform Act:

1. "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Insurance Commissioner that a small employer carrier is in compliance with the provisions of Section 6515 of this title, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans;

2. "Affiliate" or "affiliated" means any entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person;

3. "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or which could have

been charged under a rating system for that class of business, by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage;

4. "Basic health benefit plan" means a lower cost health benefit plan adopted by the state for small employer groups;

5. "Board" means the board of directors of the program established pursuant to Section 6522 of this title;

6. "Carrier" means any entity which provides health insurance in this state. For the purposes of the Small Employer Health Insurance Reform Act, carrier includes a licensed insurance company, not-for-profit hospital service or medical indemnity corporation, a fraternal benefit society, a health maintenance organization, a multiple employer welfare arrangement or any other entity providing a plan of health insurance or health benefits subject to state insurance regulation;

7. "Case characteristics" means demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer, provided that claim experience, health status and duration of coverage shall not be case characteristics for the purposes of the Small Employer Health Insurance Reform Act. A small employer carrier shall not use case characteristics, other than age, gender, industry, geographic area and family composition, without prior

approval of the Insurance Commissioner. Group size shall not be used as a case characteristic;

8. "Class of business" means all or a separate grouping of small employers established pursuant to Section 6514 of this title. Group size shall not be used as a class of business;

9. "Commissioner" means the Insurance Commissioner;

10. "Control" (including the terms "controlling", "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing that control does not exist in fact in the manner provided in Section 1654 of this title. The Commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect;

11. "Department" means the Insurance Department;

12. "Dependent" means a spouse, an unmarried child under the age of eighteen (18), an unmarried child who is a full-time student under the age of twenty-three (23) and who is financially dependent upon the parent, and an unmarried child of any age who is medically certified as disabled and dependent upon the parent;

13. "Eligible employee" means an employee who works on a full-time basis ~~and has~~ or, at the option of the employer, an employee who works on a part-time basis with a normal work week of twenty-four (24) or more hours. The term includes a sole proprietor, a partner of a partnership, and associates of a limited liability company, if the sole proprietor, partner or associate is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a ~~part-time,~~ temporary or substitute basis;

14. "Established geographic service area" means a geographic area, as approved by the Commissioner and based on the carrier's certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage;

15. a. "Health benefit plan" means any hospital or medical policy or certificate; contract of insurance provided by a not-for-profit hospital service or medical indemnity plan; or prepaid health plan or health maintenance organization subscriber contract.

b. Health benefit plan does not include accident-only, credit, dental, vision, Medicare supplement, long-term care, or disability income insurance, coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, any plan certified by the Oklahoma Basic Health Benefits Board, or automobile medical payment insurance.

c. "Health benefit plan" shall not include policies or certificates of specified disease, hospital confinement indemnity or limited benefit health insurance, provided that the carrier offering such policies or certificates complies with the following:

(1) the carrier files on or before March 1 of each year a certification with the Commissioner that contains the statement and information described in division (2) of this subparagraph,

(2) the certification required in division (1) of this subparagraph shall contain the following:

(a) a statement from the carrier certifying that policies or certificates described in this subparagraph are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense

insurance or major medical expense insurance, and

(b) a summary description of each policy or certificate described in this subparagraph, including the average annual premium rates (or range of premium rates in cases where premiums vary by age, gender or other factors) charged for such policies and certificates in this state, and

(3) in the case of a policy or certificate that is described in this subparagraph and that is offered for the first time in this state on or after the effective date of this act, the carrier files with the Commissioner the information and statement required in division (2) of this subparagraph at least thirty (30) days prior to the date such a policy or certificate is issued or delivered in this state;

16. "Index rate" means, for each class of business as to a rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate;

17. "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer

following the initial enrollment period during which the individual is entitled to enroll under the terms of the health benefit plan, provided that the initial enrollment period is a period of at least thirty-one (31) days. However, an eligible employee or dependent shall not be considered a late enrollee if:

a. the individual meets each of the following:

(1) the individual was covered under qualifying previous coverage at the time of the initial enrollment,

(2) the individual lost coverage under qualifying previous coverage as a result of termination of employment or eligibility, the involuntary termination of the qualifying previous coverage, death of a spouse or divorce, and

(3) the individual requests enrollment within thirty (30) days after termination of the qualifying previous coverage,

b. the individual is employed by an employer which offers multiple health benefit plans and the individual elects a different plan during an open enrollment period, or

c. a court has ordered coverage be provided for a spouse or minor or dependent child under a covered employee's health benefit plan and request for enrollment is made

within thirty (30) days after issuance of the court order;

18. "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered, or which could have been charged or offered, by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage;

19. "Plan of operation" means the plan of operation of the program established pursuant to Section 6522 of this title;

20. "Premium" means all monies paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan;

21. "Program" means the Oklahoma Small Employer Health Reinsurance Program created pursuant to Section 6522 of this title;

22. "Qualifying previous coverage" and "qualifying existing coverage" mean benefits or coverage provided under:

a. Medicare or Medicaid,

b. an employer-based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan, or

c. an individual health insurance policy, including coverage issued by a health maintenance organization, fraternal benefit society and those entities set forth in Section 2501 et seq. of Title 63 of the Oklahoma Statutes, that provides benefits similar to or exceeding the benefits provided under the basic health benefit plan, provided that such policy has been in effect for a period of at least one (1) year;

23. "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect;

24. "Reinsuring carrier" means a small employer carrier participating in the reinsurance program pursuant to Section 6522 of this title;

25. "Restricted network provision" means any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier pursuant to Section 2501 et seq. of Title 63 of the Oklahoma Statutes to provide health care services to covered individuals;

26. "Risk-assuming carrier" means a small employer carrier whose application is approved by the Commissioner pursuant to Section 6521 of this title;

27. "Small employer" means any person, firm, corporation, partnership, limited liability company or association that is actively engaged in business that, on at least fifty percent (50%) of its working days during the preceding calendar quarter, employed no more than fifty (50) eligible employees, the majority of whom were employed within this state. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state income taxation, shall be considered one employer;

28. "Small employer carrier" means a carrier that offers health benefit plans covering eligible employees of one or more small employers in this state; and

29. "Standard health benefit plan" means the health benefit plan adopted by the state for small employers.

SECTION 51. AMENDATORY 36 O.S. 2001, Section 6602, as last amended by Section 17, Chapter 353, O.S.L. 2008 (36 O.S. Supp. 2008, Section 6602), is amended to read as follows:

Section 6602. As used in the Service Warranty Insurance Act:

1. "Commissioner" means the Insurance Commissioner;

2. "Consumer product" means tangible personal property primarily used for personal, family, or household purposes;

3. "Department" means the Insurance Department;

4. "Gross income" means the total amount of revenue received in connection with business-related activity;

5. “Gross written premiums” means the total amount of premiums, inclusive of commissions, for which the association is obligated under service warranties issued in this state;

6. “Impaired” means having liabilities in excess of assets;

7. “Indemnify” means to undertake repair or replacement of a consumer product or a newly-constructed residential structure, including any appliances, electrical, plumbing, heating, cooling or air conditioning systems, in return for the payment of a segregated premium, when the consumer product or residential structure becomes defective or suffers operational failure;

8. “Insolvent” means any actual or threatened delinquency including, but not limited to, any one or more of the following circumstances:

a. an association’s total liabilities exceed the association’s total assets excluding goodwill, franchises, customer lists, patents or trademarks, and receivables from or advances to officers, directors, employees, salesmen, and affiliated companies. In order to include receivables from affiliated companies as assets as defined pursuant to this subparagraph and paragraph 10 of this section, the service warranty association shall provide a written guarantee to assure repayment of all receivables, loans, and advances from affiliated companies. The written

guarantee must be made by a guaranteeing organization which:

(1) has been in continuous operation for ten (10) years or more and has net assets in excess of Five Hundred Million Dollars ($500,000,000.00),

(2) submits a guarantee on a form ~~provided by~~ acceptable to the Insurance Commissioner ~~by rule~~ that contains a provision which requires that the guarantee be irrevocable, unless the guaranteeing organization can demonstrate to the Commissioner's satisfaction that the cancellation of the guarantee will not result in the net assets of the service warranty association falling below its minimum net asset requirement and the Commissioner approves cancellation of the guarantee,

(3) initially submits a statement from a certified public accountant of the guaranteeing organization attesting that the net assets of the guaranteeing organization meets or exceeds the net assets requirement as provided in division (1) of this subparagraph and that the net assets of the guaranteeing organization exceed the amount of the receivable of the service warranty

association that is being guaranteed by the guaranteeing organization, ~~and~~

(4) submits annually to the Commissioner, within three (3) months after the end of its fiscal year, with the annual statement required by Section 6615 of this title, a statement from an independent certified public accountant ~~of the guaranteeing organization~~ attesting that the net assets of the guaranteeing organization meet or exceed the net assets requirement as provided in division (1) of this subparagraph and that the net assets of the guaranteeing organization exceed the amount of the receivable of the service warranty association that is being guaranteed by the guaranteeing organization, and

(5) the receivables are maintained as cash or as marketable securities,

b. the business of any such association is being conducted fraudulently, or

c. the association has knowingly overvalued its assets;

9. "Insurer" means any property or casualty insurer duly authorized to transact such business in this state;

10. "Net assets" means the amount by which the total assets of an association, excluding goodwill, franchises, customer lists,

patents or trademarks, and receivables from or advances to officers, directors, employees, salesmen, and affiliated companies, exceed the total liabilities of the association. For purposes of the Service Warranty Insurance Act, the term "total liabilities" does not include the capital stock, paid-in capital, or retained earning of an association unless a written guaranty assures repayment and meets the conditions specified in subparagraph a of paragraph 8 of this section;

11. "Person" includes an individual, company, corporation, association, insurer, agent and any other legal entity;

12. "Premium" means the total consideration received or to be received, including sales commissions, by whatever name called, by a service warranty association for, or related to, the issuance and delivery of a service warranty, including any charges designated as assessments or fees for membership, policy, survey, inspection, or service or other charges. However, a repair charge is not a premium unless it exceeds the usual and customary repair fee charged by the association, provided the repair is made before the issuance and delivery of the warranty;

13. "Sales representative" means any person utilized by an insurer or service warranty association for the purpose of selling or issuing service warranties and includes any individual possessing a certificate of competency who has the power to legally obligate the insurer or service warranty association or who merely acts as

the qualifying agent to qualify the association in instances when a state statute or local ordinance requires a certificate of competency to engage in a particular business;

14. "Service warranty" means a contract or agreement for a separately stated consideration for a specific duration to perform the repair or replacement of property or indemnification for repair or replacement for the operational or structural failure due to a defect or failure in materials or workmanship, with or without additional provision for incidental payment of indemnity under limited circumstances, including, but not limited to, failure due to normal wear and tear, towing, rental and emergency road service, road hazard, power surge, and accidental damage from handling or as otherwise provided for in said contract or agreement; however:

a. maintenance service contracts under the terms of which there are no provisions for such indemnification are expressly excluded from this definition,

b. those contracts issued solely by the manufacturer, distributor, importer or seller of the product, or any affiliate or subsidiary of the foregoing entities, whereby such entity has contractual liability insurance in place, from an insurer licensed in the state, which covers one hundred percent (100%) of the claims exposure on all contracts written without being predicated on the failure to perform under such

contracts, are expressly excluded from this definition,

c. the term "service warranty" does not include service contracts entered into between consumers and nonprofit organizations or cooperatives the members of which consist of condominium associations and condominium owners, which contracts require the performance of repairs and maintenance of appliances or maintenance of the residential property,

d. the term "service warranty" does not include warranties, guarantees, extended warranties, extended guarantees, contract agreements or any other service contracts issued by a company which performs at least seventy percent (70%) of the service work itself and not through subcontractors, which has been selling and honoring such contracts in Oklahoma for at least twenty (20) years, and

e. the term "service warranty" does not include warranties, guarantees, extended warranties, extended guarantees, contract agreements or any other service contracts, whether or not such service contracts otherwise meet the definition of service warranty, issued by a company which has net assets in excess of One Hundred Million Dollars ($100,000,000.00). A

service warranty association may use the net assets of a parent company to qualify under this section if the net assets of the company issuing the policy total at least Twenty-five Million Dollars ($25,000,000.00) and the parent company maintains net assets of at least Seventy-five Million Dollars ($75,000,000.00) not including the net assets held by the service warranty associations;

15. "Service warranty association" or "association" means any person, other than an authorized insurer, contractually obligated to a service contract holder under the terms of a service warranty; provided, this term shall not mean any person engaged in the business of erecting or otherwise constructing a new home;

16. "Warrantor" means any service warranty association engaged in the sale of service warranties and deriving not more than fifty percent (50%) of its gross income from the sale of service warranties; and

17. "Warranty seller" means any service warranty association engaged in the sale of service warranties and deriving more than fifty percent (50%) of its gross income from the sale of service warranties.

SECTION 52. AMENDATORY 36 O.S. 2001, Section 6607, as amended by Section 20, Chapter 353, O.S.L. 2008 (36 O.S. Supp. 2008, Section 6607), is amended to read as follows:

Section 6607. A. An association licensed pursuant to the Service Warranty Insurance Act shall maintain a funded, unearned premium reserve account, consisting of unencumbered assets, equal to a minimum of twenty-five percent (25%) of the gross written premiums received on all warranty contracts in force, wherever written. In the case of multiyear contracts which are offered by associations having net assets of less than Five Hundred Thousand Dollars ($500,000.00) for which premiums are collected in advance for coverage in a subsequent year, one hundred percent (100%) of the premiums for such subsequent years shall be placed in the funded, unearned premium reserve account. Additionally, an association establishing such reserve account shall also place in trust with the Insurance Commissioner a surety bond issued by an authorized surety having a value of not less than five percent (5%) of the gross premium received, less claims paid, on the sale of the service warranties for all service contracts issued and in force in this state, but in no event shall the bond be less than Twenty-five Thousand Dollars ($25,000.00).

B. An association shall not be required to establish an unearned premium reserve ~~or demonstrate minimum net worth~~ if it has purchased an insurance policy which demonstrates to the satisfaction of the Insurance Commissioner that one hundred percent (100%) of its claim exposure is covered by such policy and satisfies the requirements of this section. The insurance shall be obtained from

an insurer that is licensed, registered, or otherwise authorized to do business in this state, that is rated B++ or better by A.M. Best Company, Inc. and that meets the requirements of subsection C of this section. For the purposes of this subsection, the insurance policy shall contain the following provisions:

1. In the event that the service warranty association is unable to fulfill its obligation under contracts issued in this state for any reason, including insolvency, bankruptcy, or dissolution, the insurer will pay losses and unearned premiums under such plans directly to the person making a claim under the contract;

2. The insurer issuing the insurance policy shall assume full responsibility for the administration of claims in the event of the inability of the association to do so; and

3. The policy may not be canceled or not renewed by either the insurer or the association unless sixty (60) days' written notice thereof has been given to the Commissioner by the insurer before the date of such cancellation or nonrenewal.

C. The insurer providing the insurance policy used to satisfy the financial responsibility requirements of subsection B of this section must meet one of the following standards:

1. The insurer shall, at the time the policy is filed with the Commissioner, and continuously thereafter:

a. maintain surplus as to policyholders and paid-in capital of at least Fifteen Million Dollars ($15,000,000.00), and

b. annually file copies of the audited financial statements of the insurer, its NAIC Annual Statement, and the actuarial certification required by and filed in the state of domicile of the insurer; or

2. The insurer shall, at the time the policy is filed with the Commissioner, and continuously thereafter:

a. maintain surplus as to policyholders and paid-in capital of less than Fifteen Million Dollars ($15,000,000.00) but at least equal to Ten Million Dollars ($10,000,000.00),

b. demonstrate to the satisfaction of the Commissioner that the company maintains a ratio of net written premiums, wherever written, to surplus as to policyholders and paid-in capital of not greater than three to one, and

c. annually file copies of the audited financial statements of the insurer, its NAIC Annual Statement, and the actuarial certification required by and filed in the state of domicile of the insurer.

D. No warrantor or warranty seller shall allow its gross written premiums to exceed seven to one ratio to net assets.

E. If the gross written premiums of a warrantor or a warranty seller exceed the required net asset ratios, the Commissioner may require, in addition to other measures as the Commissioner deems necessary, any one or more of the following:

1. A complete review of financial condition;

2. An increase in deposit;

3. A suspension of any new writings; or

4. Capital infusion into the business.

SECTION 53. AMENDATORY 36 O.S. 2001, Section 6608, is amended to read as follows:

Section 6608. A. An application for license as a service warranty association shall be made to, and filed with, the Insurance Commissioner on printed forms as prescribed and furnished by the Insurance Commissioner.

B. In addition to information relative to its qualifications as required under Section ~~5~~ 6605 of this ~~act~~ title, the Commissioner may require that the application show:

1. The location of the home office of the applicant;

2. The name and residence address of each director or officer of the applicant; and

3. Such other pertinent information as may be required by the Commissioner.

C. The Commissioner may require that the application, when filed, be accompanied by:

1. A copy of the articles of incorporation of the applicant, certified by the public official having custody of the original, and a copy of the bylaws of the applicant, certified by the chief executive officer of the applicant;

2. A copy of the most recent financial statement of the applicant, verified under oath of at least two of its principal officers; and

3. A license fee in the amount of Two Hundred Dollars ($200.00) as required pursuant to Section ~~4~~ 6604 of this ~~act~~ title.

D. Upon completion of the application for license, the Commissioner shall examine the application and make such further investigation of the applicant as the Commissioner deems advisable. If the Commissioner finds that the applicant is qualified, the Commissioner shall issue to the applicant a license as a service warranty association. If the Commissioner does not find the applicant to be qualified the Commissioner shall refuse to issue the license and shall give the applicant written notice of such refusal, setting forth the grounds therefor.

E. 1. Any entity that claims one or more of the exclusions from the definition of service warranty provided in paragraph 14 of Section 6602 of this title shall file financial statements and other information as requested by the Commissioner by May 1, 2010, to document and verify that the entity's contracts are not included within the definition of service warranty.

2. Any entity that fails to meet the May 1, 2010, deadline or that begins claiming an exclusion exemption provided by paragraph 14 of Section 6602 of this title after May 1, 2010, shall file financial statements and other information as requested by the Commissioner prior to conducting or continuing business in this state.

3. Any entity approved for an exclusion provided by paragraph 14 of Section 6602 of this title may be required by the Commissioner to provide subsequent financial statements and other information ascertained by the Commissioner to be necessary to determine continued qualification for an exclusion provided by paragraph 14 of Section 6602 of this title.

4. Other information as requested by the Commissioner may include, but is not limited to, audited financial statements, SEC filings, financial statements of affiliates, and organizational data and organizational charts.

SECTION 54. AMENDATORY Section 11, Chapter 390, O.S.L. 2003 (36 O.S. Supp. 2008, Section 6810), is amended to read as follows:

Section 6810. MEDICAL PROFESSIONAL LIABILITY INSURANCE CLOSED CLAIM REPORTS

A. Sections 6810 through 6820 of this title shall be known and may be cited as the "Medical Professional Liability Insurance Closed Claim Reports Act".

B. As used in ~~Sections 12 through 21 of this act, the following words, terms, or phrases shall have the following meanings, unless the context otherwise clearly indicates~~ the Medical Professional Liability Insurance Closed Claim Reports Act:

1. ~~"Insurer" means an insurance company or other entity that is or has been authorized to write medical professional liability insurance in this state; and~~

~~2. "Medical professional liability insurance" means any insurance that provides professional liability coverage for any health care provider as defined in Section 1 1708.1C of Title 63 of the Oklahoma Statutes~~ "Claim" means:

a. a demand for monetary damages for injury or death caused by medical malpractice, or

b. a voluntary indemnity payment for injury or death caused by medical malpractice;

2. "Claimant" means a person, including an estate of a decedent, who is seeking or has sought monetary damages for injury or death caused by medical malpractice;

3. "Closed claim" means a claim that has been settled or otherwise disposed of by the insuring entity, self-insurer, facility, or provider. A claim may be closed with or without an indemnity payment to a claimant;

4. "Commissioner" means the Insurance Commissioner;

5. “Companion claims” means separate claims involving the same incident of medical malpractice made against other providers or facilities;

6. “Economic damages” means objectively verifiable monetary losses, including medical expenses, loss of earnings, burial costs, loss of use of property, cost of replacement or repair, cost of obtaining substitute domestic services, and loss of business or employment opportunities;

7. “Health care facility” or “facility” means a clinic, diagnostic center, hospital, laboratory, mental health center, nursing home, office, surgical facility, treatment facility, or similar place where a health care provider provides health care to patients;

8. “Health care provider” or “provider” means:

a. a person licensed to provide health care or related services, including an acupuncturist, doctor of medicine or osteopathy, a dentist, a nurse, an optometrist, a podiatric physician and surgeon, a chiropractor, a physical therapist, a psychologist, a pharmacist, an optician, a physician’s assistant, a midwife, an osteopathic physician’s assistant, a nurse practitioner, or a physician’s trained mobile intensive care paramedic. If the person is deceased,

this includes the estate or personal representative of the person, or

b. an employee or agent of a person described in subparagraph a of this paragraph, acting in the course and scope of the employment of the employee. If the employee or agent is deceased, this includes the estate or personal representative of the employee;

9. "Insuring entity" means:

a. an authorized insurer,

b. a captive insurer,

c. a joint underwriting association,

d. a patient compensation fund,

e. a risk retention group, or

f. an unauthorized insurer that provides surplus lines coverage;

10. "Medical malpractice" means an actual or alleged negligent act, error, or omission in providing or failing to provide health care services;

11. "Noneconomic damages" means subjective, nonmonetary losses, including pain, suffering, inconvenience, mental anguish, disability or disfigurement incurred by the injured party, emotional distress, loss of society and companionship, loss of consortium, humiliation and injury to reputation, and destruction of the parent-child relationship; and

12. "Self-insurer" means any health care provider, facility, or other individual or entity that assumes operational or financial risk for claims of medical professional liability.

SECTION 55. AMENDATORY Section 12, Chapter 390, O.S.L. 2003 (36 O.S. Supp. 2008, Section 6811), is amended to read as follows:

Section 6811. A. Not later than the tenth day after the last day of the calendar quarter in which a claim for recovery under a medical professional liability insurance policy is closed, the insurer shall file with the Insurance Department a closed claim report. These reports must include data for all claims closed in the preceding calendar year and any adjustments to data reported in prior years.

B. Any violation by an insurer of the Medical Professional Liability Insurance Closed Claim Reports Act shall subject the insurer to discipline including a civil penalty of not less than Five Thousand Dollars ($5,000.00).

C. Every insuring entity or self-insurer that provides medical professional liability insurance to any facility or provider in this state must report each medical professional liability closed claim to the Insurance Commissioner.

D. A closed claim that is covered under a primary policy and one or more excess policies shall be reported only by the insuring entity that issued the primary policy. The insuring entity that

issued the primary policy shall report the total amount, if any, paid with respect to the closed claim, including any amount paid under an excess policy, any amount paid by the facility or provider, and any amount paid by any other person on behalf of the facility or provider.

E. If a claim is not covered by an insuring entity or self-insurer, the facility or provider named in the claim must report it to the Commissioner after a final claim disposition has occurred due to a court proceeding or a settlement by the parties. Instances in which a claim may not be covered by an insuring entity or self-insurer include situations in which:

1. The facility or provider did not buy insurance or maintained a self-insured retention that was larger than the final judgment or settlement;

2. The claim was denied by an insuring entity or self-insurer because it did not fall within the scope of the insurance coverage agreement; or

3. The annual aggregate coverage limits had been exhausted by other claim payments.

F. If a claim is covered by an insuring entity or self-insurer that fails to report the claim to the Commissioner, the facility or provider named in the claim must report it to the Commissioner after a final claim disposition has occurred due to a court proceeding or a settlement by the parties.

1. If a facility or provider is insured by a risk retention group and the risk retention group refuses to report closed claims and asserts that the federal Liability Risk Retention Act (95 Stat. 949; 15 U.S.C. Sec. 3901 et seq.) preempts state law, the facility or provider must report all data required by the Medical Professional Liability Insurance Closed Claim Reports Act on behalf of the risk retention group.

2. If a facility or provider is insured by an unauthorized insurer and the unauthorized insurer refuses to report closed claims and asserts a federal exemption or other jurisdictional preemption, the facility or provider must report all data required by the Medical Professional Liability Insurance Closed Claim Reports Act on behalf of the unauthorized insurer.

3. If a facility or provider is insured by a captive insurer and the captive insurer refuses to report closed claims and asserts a federal exemption or other jurisdictional preemption, the facility or provider must report all data required by the Medical Professional Liability Insurance Closed Claim Reports Act on behalf of the captive insurer.

SECTION 56. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6812.1 of Title 36, unless there is created a duplication in numbering, reads as follows:

Reports required under Section 6811 of this title must contain the following information in a format and coding protocol prescribed

by the Insurance Commissioner. To the greatest extent possible while still fulfilling the purposes of the Medical Professional Liability Insurance Closed Claim Reports Act, the format and coding protocol shall be consistent with the format and coding protocol for data reported to the National Practitioner Data Bank.

1. Claim and incident identifiers, including:

a. a claim identifier assigned to the claim by the insuring entity, self-insurer, facility, or provider, and

b. an incident identifier if companion claims have been made by a claimant;

2. The policy limits of the medical professional liability insurance policy covering the claim;

3. The medical specialty of the provider who was primarily responsible for the medical malpractice incident that led to the claim;

4. The type of health care facility where the medical malpractice incident occurred;

5. The primary location within a facility where the medical malpractice incident occurred;

6. The geographic location, by city and county, where the medical malpractice incident occurred;

7. The sex and age of the injured person on the incident date;

8. The severity of malpractice injury using the National Practitioner Data Bank severity scale;

9. The dates of:

a. the earliest act or omission by the defendant that was the proximate cause of the claim,

b. notice to the insuring entity, self-insurer, facility, or provider,

c. suit, if a suit was filed,

d. final indemnity payment, if any, and

e. final action by the insuring entity, self-insurer, facility, or provider to close the claim;

10. Settlement information that identifies the timing and final method of claim disposition, including:

a. claims settled by the parties,

b. claims disposed of by a court, including the date disposed,

c. claims disposed of by alternative dispute resolution, such as arbitration, mediation, private trial, and other common dispute resolution methods, and

d. whether the settlement occurred before or after trial, if a trial occurred;

11. Specific information about the indemnity payments and defense and cost-containment expenses, including:

a. for claims disposed of by a court that result in a verdict or judgment that itemizes damages:

(1) the indemnity payment made on behalf of the defendant,

(2) economic damages,

(3) noneconomic damages,

(4) punitive damages, if applicable, and

(5) defense and cost-containment expenses, including court costs, attorney fees, and costs of expert witnesses, and

b. for claims that do not result in a verdict or judgment that itemizes damages:

(1) the total amount of the settlement on behalf of the defendant,

(2) the insuring entity's or self-insurer's best estimate of economic damages included in the settlement,

(3) the insuring entity's or self-insurer's best estimate of noneconomic damages included in the settlement, and

(4) defense and cost-containment expenses, including court costs, attorney fees, and costs of expert witnesses;

12. The reason for the medical professional liability claim. The reporting entity must use the same allegation group and specific allegation codes that are used for mandatory reporting to the National Practitioner Data Bank; and

13. Any other closed claim data the Commissioner determines to be necessary to accomplish the purpose of the Medical Professional Liability Insurance Closed Claim Reports Act and requires by rule.

SECTION 57. AMENDATORY 59 O.S. 2001, Section 1306, as last amended by Section 1, Chapter 135, O.S.L. 2006 (59 O.S. Supp. 2008, Section 1306), is amended to read as follows:

Section 1306. A. 1. An applicant for a cash bondsman license shall meet all requirements set forth in Section 1305 of this title with exception of residence.

2. In addition to the requirements prescribed in Section 1305 of this title, an applicant for a professional bondsman license shall submit to the Insurance Commissioner financial statements prepared by an accounting firm or individual holding a permit to practice public accounting in this state in accordance with generally accepted principles of accounting procedures setting forth the total assets of the bondsman less liabilities and debts as follows: For all applications made prior to ~~the effective date of this act~~ November 1, 2006, and the subsequent renewals of a license issued upon such application when continuously maintained in effect as required by law, the statement shall show a net worth of at least

Fifty Thousand Dollars ($50,000.00). For all applications made on and after ~~the effective date of this act~~ November 1, 2006, and the subsequent renewals of a license issued upon such application when continuously maintained in effect as required by law, or for the renewal or reinstatement of any license that is expired pursuant to subsection D of Section 1309 of this title, suspended or revoked, the statement shall show a net worth of at least One Hundred Fifty Thousand Dollars ($150,000.00), said statements to be current as of a date not earlier than ninety (90) days prior to submission of the application and the statement shall be attested to by an unqualified opinion of the accountant.

3. Professional bondsman applicants shall make a deposit with the Insurance Commissioner in the same manner as required of domestic insurance companies of an amount to be determined by the Commissioner. For all applications made prior to ~~the effective date of this act~~ November 1, 2006, and the subsequent renewals of a license issued upon such application when continuously maintained in effect as required by law, the deposit shall not be less than Twenty Thousand Dollars ($20,000.00). For all applications made on and after ~~the effective date of this act~~ November 1, 2006, and the subsequent renewals of a license issued upon such application when continuously maintained in effect as required by law, or for the renewal or reinstatement of any license that is expired pursuant to subsection D of Section 1309 of this title, suspended or revoked,

the deposit shall not be less than Fifty Thousand Dollars ($50,000.00). Such deposits shall be subject to all laws, rules and regulations as deposits by domestic insurance companies but in no instance shall a professional bondsman write bonds which equal more than ten times the amount of the deposit which such bondsman has submitted to the Commissioner. Such deposit shall require the review and approval of the Insurance Commissioner prior to exceeding the maximum amount of Federal Deposit Insurance Corporation basic deposit coverage for any one bank or financial institution. In addition, a professional bondsman may make the deposit by purchasing an annuity through a licensed domestic insurance company in the State of Oklahoma. The annuity shall be in the name of the bondsman as owner with legal assignment to the Insurance Commissioner. The assignment form shall be approved by the Commissioner. If a bondsman exceeds the above limitation, the bondsman shall be notified by the Commissioner by mail with return receipt requested that the excess shall be reduced or the deposit increased within ten (10) days of notification, or the license of the bondsman shall be suspended immediately after the ten-day period, pending a hearing on the matter.

4. The deposit herein provided for shall constitute a reserve available to meet sums due on forfeiture of any bonds or recognizance executed by such bondsman.

5. Any deposit made by a professional bondsman pursuant to this section shall be released and returned by the Commissioner to the professional bondsman only upon extinguishment of all liability on outstanding bonds.

6. No release of deposits to a professional bondsman shall be made by the Commissioner except upon written application and the written order of the Commissioner. The Commissioner shall have no liability for any such release to a professional bondsman provided the release was made in good faith.

B. The deposit provided in this section shall be held in safekeeping by the Insurance Commissioner and shall only be used if a bondsman fails to pay an order and judgment of forfeiture after being properly notified or shall be used if the license of a professional bondsman has been revoked. The deposit shall be held in the name of the Insurance Commissioner and the bondsman. The bondsman shall execute an assignment of the deposit to the Insurance Commissioner for the payment of unpaid bond forfeitures.

C. Currently licensed professional bondsmen may maintain their aggregate liability limits upon presentation of documented proof that they have previously been granted a limitation greater than the requirements of subsection A of this section.

D. Notwithstanding any other provision of Section 1301 et seq. of this title, the license of a professional bondsman is transferable upon the death or legal or physical incapacitation of

the bondsman to the bondsman's spouse, or to such other transferee as the professional bondsman may designate in writing, and the transferee may elect to act as a professional bondsman until the expiration of the license or for a period of one hundred eighty (180) days, whichever is greater, if the following conditions are met:

1. The transferee must hold a valid license as a surety bondsman in this state; and

2. The asset and deposit requirements set forth in this section continue to be met.

SECTION 58. AMENDATORY 59 O.S. 2001, Section 1316, as last amended by Section 29, Chapter 184, O.S.L. 2008 (59 O.S. Supp. 2008, Section 1316), is amended to read as follows:

Section 1316. A. 1. A bail bondsman shall neither sign nor countersign in blank any bond, nor shall the bondsman give a power of attorney to, or otherwise authorize, anyone to countersign his or her name to bonds unless the person so authorized is a licensed surety bondsman or managing general agent directly employed by a licensed professional bondsman giving such power of attorney. The professional bondsman shall submit to the Insurance Commissioner the agreement between the professional bondsman and the employed bondsman. The agreement shall be submitted to the Commissioner prior to the employed bondsman writing bonds on behalf of the professional. The professional bondsman shall notify the

Commissioner whenever any agreement is canceled. If the bondsman surrenders the professional qualification, or the professional qualification is suspended or revoked, then the Commissioner shall suspend the appointment of all of the professional bondsman's bail agents. The Commissioner shall immediately notify any bail agent whose license is affected and the court clerk of the agent's resident county upon such suspension or revocation of the professional bondsman's qualification. If the professional qualification is reinstated within twenty-four (24) hours, the Commissioner shall not be required to suspend the bail agent appointments. If the Commissioner reinstates the professional qualification within twenty-four (24) hours, the Commissioner shall also reinstate the appointment of the professional bondsman's bail agents. If more than twenty-four (24) hours elapse following the suspension or revocation, then the professional bondsman shall submit new agent appointments to the Commissioner.

2. Bail bondsmen shall not allow other licensed bondsmen to present bonds that have previously been signed and completed ~~by other licensed bondsmen unless a written authorization is on file with the court clerk where the bond is filed~~. The individual that presents the bond shall sign the form in the presence of the official that receives the bond.

B. Premium charged must be indicated on the appearance bond prior to the filing of the bond.

C. A bail bondsman shall provide the indemnitors with a proper receipt which shall include fees, premium or other payments and copies of any agreements executed relating to the appearance bond.

D. All surety bondsmen or managing general agents shall attach a completed power of attorney to the appearance bond that is filed with the court clerk on each bond written.

E. Any bond written in this state shall contain the name and last-known mailing address of the bondsman and, if applicable, of the insurer.

SECTION 59. REPEALER 36 O.S. 2001, Section 1425.5, is hereby repealed.

SECTION 60. REPEALER 36 O.S. 2001, Section 6204, is hereby repealed.

SECTION 61. REPEALER Section 13, Chapter 390, O.S.L. 2003, as amended by Section 71, Chapter 264, O.S.L. 2006 (36 O.S. Supp. 2008, Section 6812), is hereby repealed.

SECTION 62. This act shall become effective November 1, 2009.

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