UNFAIR LIFE, ACCIDENT AND HEALTH CLAIMS SETTLEMENT PRACTICES MODEL REGULATION

Table of Contents

Section 1. Authority
Section 2. Purpose
Section 3. Definitions
Section 4. Claims Practices
Section 5. File and Record Documentation

Section 1. Authority

This regulation is adopted under the authority of the Unfair Claims Settlement Practices Act.

Section 2. Purpose

The purpose of this regulation is to set forth minimum standards for the investigation and disposition of life, accident and health claims arising under policies or certificates issued pursuant to State law. It is not intended to cover claims involving workers' compensation insurance. The various provisions of this regulation are intended to define procedures and practices which constitute unfair claims practices. Nothing herein shall be construed to create or imply a private cause of action for violation of this regulation. This is merely a clarification of original intent and does not indicate of any change of position.

Drafting Note: Any jurisdiction choosing to provide for a private cause of action should consider a different statutory scheme. This regulation is inherently inconsistent with a private cause of action. The NAIC has separately promulgated an Unfair Property/Casualty Claims Settlement Practices Model Regulation.

Section 3. Definitions

All definitions contained in the Unfair Claims Settlement Practices Act (or Unfair Trade Practices Model Act) are hereby incorporated by reference. As otherwise used in this regulation:

A. "Agent" means any individual, corporation, association, partnership or other legal entity authorized to represent an insurer with respect to a claim;

B. "Beneficiary" means the party entitled to receive the proceeds or benefits occurring under the policy in lieu of the insured;

C. "Claim file" means any retrievable electronic file, paper file or combination of both;

D. "Claimant" means an insured, the beneficiary or legal representative of the insured, including a member of the insured's immediate family designated by the insured, making a claim under a policy;

E. "Days" means calendar days;

F. "Documentation" includes, but is not limited to, all pertinent communications, transactions, notes, work papers, claim forms, bills and explanation of benefits forms relative to the claim;

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

H. "Limited insurance representative" means an individual, partnership or corporation who is authorized by the Commissioner to solicit or negotiate certificates or policies for a particular line of insurance which the Commissioner may by regulation deem essential for the transaction of business in this State and which does not require the professional competency demanded for an insurance agent's or insurance broker's license.

I. "Notification of claim" means any notification, whether in writing or other means acceptable under the terms of an insurance policy to an insurer or its agent, by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim;

J. "Proof of loss" means written proofs, such as claim forms, medical bills, medical authorizations or other reasonable evidence of the claim that is ordinarily required of all insureds or beneficiaries submitting the claims;

K. "Reasonable explanation" means information sufficient to enable the insured or beneficiary to compare the allowable benefits with policy provisions and determine whether proper payment has been made;

L. "Written communications" includes all correspondence, regardless of source or type that is materially related to the handling of the claim.

Section 4. Claims Practices

A. Every insurer, upon receiving due notification of a claim shall, within fifteen (15) days of the notification, provide necessary claim forms, instructions and reasonable assistance so the insured can properly comply with company requirements for filing a claim.

B. Upon receipt of proof of loss from a claimant, the insurer shall begin any necessary investigation of the claim within fifteen (15) days.

C. The insurer's standards for claims processing shall be such that notice of claim or proof of loss submitted against one policy issued by that insurer shall fulfill the insured's obligation under any and all similar policies issued by that insurer and specifically identified by the insured to the insurer to the same degree that the same form would be required under any similar policy. If additional information is required to fulfill the insured's obligation under similar policies, the insurer may request the additional information. When it is apparent to the insurer that additional benefits would be payable under an insured's policy upon additional proofs of loss, the insurer shall communicate to and cooperate with the insured in determining the extent of the insurer's additional liability.

D. The insurer shall affirm or deny liability on claims within a reasonable time and shall offer payment within thirty (30) days of affirmation of liability if the amount of the claim is determined and not in dispute. If portions of the claim are in dispute, the insurer shall tender payment for those portions that are not disputed within thirty (30) days.

E. With each claim payment, the insurer shall provide to the insured an Explanation of Benefits that shall include the name of the provider or services covered, dates of service, and a reasonable explanation of the computation of benefits.

F. An insurer may not impose a penalty upon any insured for noncompliance with insurer requirements for precertification unless such penalty is specifically and clearly set forth in the policy.

G. If a claim remains unresolved for thirty (30) days from the date proof of loss is received, the insurer shall provide the insured or, when applicable, the insured's beneficiary, with a reasonable written explanation for the delay. In credit, mortgage and assigned accident/health claims, the notice shall be provided to the debtor/insured or medical provider in addition to the insured. If the investigation remains incomplete, the insurer shall, forty-five (45) days from the date of initial notification and every forty-five (45) days thereafter, send to the claimant a letter setting forth the reasons additional time is needed for investigation.

H. The insurer shall acknowledge and respond within fifteen (15) days to any written communications relating to a pending claim.

I. When a claim is denied, written notice of denial shall be sent to the claimant within fifteen (15) days of the determination. The insurer shall reference the policy provision, condition or exclusion upon which the denial is based.

J. No insurer shall deny a claim upon information obtained in a telephone conversation or personal interview with any source unless the telephone conversation or personal interview is documented in the claim file.

K. Insurers offering cash settlements of first party long-term disability income claims, except in cases where there is a bona fide dispute as to the coverage for, or amount of, the disability, shall develop a present value calculation of future benefits (with probability corrections for mortality and morbidity) utilizing contingencies such as mortality, morbidity, and interest rate assumptions, etc. appropriate to the risk. A copy of the amount so calculated shall be given to the insured and signed by him/her at the time a settlement is entered into.

L. No insurer shall indicate to a first party claimant on a payment draft, check or in any accompanying letter that said payment is "final" or "a release" of any claim unless the policy limit has been paid or there has been a compromise settlement agreed to by the first party claimant and the insurer as to coverage and amount payable under the policy.

M. No insurer shall withhold any portion of any benefit payable as a result of a claim on the basis that the sum withheld is an adjustment or correction for an overpayment made on a prior claim arising under the same policy unless:

(1) The insurer has in its files clear, documented evidence of an overpayment and written authorization from the insured permitting the withholding procedure, or

(2) The insurer has in its files clear, documented evidence that:

(a) The overpayment was clearly erroneous under the provisions of the policy and if the overpayment is not the subject of a reasonable dispute as to facts;

(b) The error that resulted in the payment is not a mistake of the law;

(c) The insurer has notified the insured within six (6) months of the date of the error, except that in instances of error prompted by representations or nondisclosures of claimants or third parties, the insurer notified the insured within fifteen (15) days after the date the evidence of discovery of such error is included in its file. For the purpose of this rule, the date of the error shall be the day on which the draft for benefits is issued; and

(d) The notice stated clearly the nature of the error and the amount of the overpayment.

N. If, after an insurer rejects a claim, the claimant objects to such rejection, the insurer shall notify the claimant in writing that he or she may have the matter reviewed by the [insert state] Department of Insurance, [insert department address and telephone number].

Section 5. File and Record Documentation

Each insurer's claim files for policies or certificates are subject to examination by the Commissioner of Insurance or by his or her duly appointed designees. To aid in the examination:

A. The insurer shall maintain claim data that are accessible and retrievable for examination. An insurer shall be able to provide the claim number, line of coverage, date of loss and date of payment of the claim, date of denial or date closed without payment. This data shall be available for all open and closed files for the current year and the two (2) preceding years.

B. Detailed documentation shall be contained in each claim file in order to permit reconstruction of the insurer's activities relative to each claim.

C. Each document within the claim file shall be noted as to date received, date processed or date mailed.

D. For those insurers that do not maintain hard copy files, claim files must be accessible from Cathode Ray Tube (CRT) or micrographics and be capable of duplication to hard copy.

Drafting Note: States are encouraged to recognize the efficiencies of electronic or other type "paperless" file systems and are encouraged to accommodate all reasonable application of such systems.

Chronological Summary of Actions (all references are to the Proceedings of the NAIC)

1990 Proc. II 7, 13-14, 160, 185-187 (adopted).
1991 Proc. I 9, 16, 192-193, 212-214 (amended and reprinted).

This document replaces a model named "Unfair Claims Settlement Practices Model Regulation."

1976 Proc. II 15, 17 342, 365, 367-370 (adopted).
1980 Proc. II 22, 26, 906, 930, 936 (amended).
1981 Proc. I 47, 51, 255, 258, 263 (amended).