

OKLAHOMA STATUTES
TITLE 36. INSURANCE

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§36-101. Short title.

Title 36 of the Oklahoma Statutes shall be known and may be cited as the Oklahoma Insurance Code.
Amended by Laws 1983, c. 68, § 1, eff. Nov. 1, 1983.

§36-102. "Insurance" defined.

"Insurance" is a contract whereby one undertakes to indemnify another or to pay a specified amount upon determinable contingencies.

Laws 1957, p. 215, § 102.

§36-103. "Insurer" defined.

A. "Insurer" includes every person engaged in the business of making contracts of insurance or indemnity.

B. A nonprofit hospital service and medical indemnity corporation is an insurer within the meaning of this Code.

C. Burial associations shall be deemed not to be insurers.

Laws 1957, p. 215, § 103.

§36-104. "Person" defined.

"Person" includes an individual, company, insurer, association, organization, society, reciprocal or inter-insurance exchange, partnership, syndicate, business trust, corporation, Lloyd's association, and entity, and association, group or department of underwriters and any farmer's educational and cooperative union.
Added by Laws 1957, p. 216, § 104, operative July 1, 1957. Amended by Laws 2004, c. 16, § 1, eff. Nov. 1, 2004.

§36-105. "Transacting" insurance.

"Transact" with respect to insurance includes any of the following:

1. Solicitation and inducement.

2. Preliminary negotiations.

3. Effectuation of a contract of insurance.

4. Transaction of matters subsequent to effectuation of the contract and arising out of it.

Laws 1957, p. 216, § 105.

§36-106. "Insurance Commissioner" defined.

A. When used with reference to administration of this Code, "Insurance Commissioner" or "Commissioner" means the Insurance Commissioner of the State of Oklahoma.

Laws 1957, p. 216, § 106.

§36-107. "Board" defined.

When used with reference to the administration of the Oklahoma Insurance Code, "State Insurance Board", "Insurance Board" or "Board" means the State Board for Property and Casualty Rates

established by Section 331, Article 3, of this Code. For purposes of the laws of this state and the Oklahoma Insurance Code, the term "Board" or "any predecessor to the Board" shall have the same meaning as the term "Insurance Commissioner".

Added by Laws 1957, p. 216, § 107, operative July 1, 1957. Amended by Laws 1965, c. 60, § 1, eff. July 1, 1965; Laws 2006, c. 264, § 1, eff. July 1, 2006.

§36-107.2. Repealed by Laws 1997, c. 418, § 125, eff. Nov. 1, 1997.

§36-107.3. Repealed by Laws 2024, c. 345, § 17, eff. Nov. 1, 2024.

§36-108. "Insurance Department" defined.

Unless the context otherwise requires, "Insurance Department" or "Department" means the Insurance Department established by Section 301, Article 3 of this Code.

Laws 1957, p. 216, § 108.

§36-109. Compliance required.

A. No person shall transact a business of insurance in Oklahoma without complying with the applicable provisions of this Code.

B. Any person and organization subject to the jurisdiction of the Insurance Commissioner, upon receipt of any inquiry from the Commissioner shall, within twenty (20) calendar days from the date of receipt of the inquiry, furnish the Commissioner with an adequate response to the inquiry. Any inquiry or response subject to this subsection shall be delivered electronically.

C. All persons and organizations subject to the jurisdiction of the Commissioner shall keep any contact information deemed necessary by the Commissioner on file with the Insurance Department. Contact information shall be kept current and be submitted electronically in the manner and form prescribed by the Commissioner, along with any applicable fees. Any change in contact information shall be submitted within twenty (20) days of the change.

Added by Laws 1957, p. 216, § 109, operative July 1, 1957. Amended by Laws 2024, c. 345, § 1, eff. Nov. 1, 2024.

§36-110. Application as to particular types of insurers.

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

1. Nonprofit hospital service and medical indemnity corporations, except as stated in Sections 601 et seq. and 2601 et seq. of this title;

2. Fraternal benefit societies, except as stated in Section 2701.1 et seq. of this title;

3. Farmers' mutual fire insurance associations, except as stated in Section 2801 et seq. of this title;

4. Mutual benefit associations, except as stated in Section 2401 et seq. of this title;

5. Domestic burial associations;

6. Any domestic association organized subject to the supervision or by the authority of any incorporated Grange Order of Patrons of Husbandry, when the association is formed exclusively for the mutual benefit of the members of such order. Effective January 1, 1982, The Oklahoma State Union of the Farmers' Educational and Cooperative Union of America shall comply with all provisions of the Oklahoma Insurance Code;

7. Trust companies organized pursuant to the provisions of Title 6 of the Oklahoma Statutes except that the title insurance and surety insurance business of such trust companies shall be subject to the Oklahoma Insurance Code;

8. Soliciting agents of mutual insurance corporations or associations, operating only in this state, that issue no stock or other form of security, do not operate for profit, and have none of their funds inure to the benefit of individuals except in the form of less expensive insurance and necessary expenses of operation, if provisions are made in the bylaws of the insurer for the election of any soliciting agents by a majority of the policyholders in the area where the soliciting agent solicits insurance;

9. The Mutual Aid Association of the Church of the Brethren or the Mutual Aid Association of the Mennonite and Brethren in Christ;

10. Incorporated or unincorporated banking associations having been in existence for over fifteen (15) years and consisting of more than seventy-five (75) member banks within this state for issuance of blanket fidelity bonds for banks within this state for each bank's own use, or any nonprofit trust sponsored by such associations' member banks providing employee benefits such as life, health, accident, disability, pension and retirement benefits for banks, bank holding companies and subsidiaries thereof, the associations' employees and associate members;

11. A religious organization, or members of the organization, if the organization:

- a. is a nonprofit religious organization,
- b. is limited to participants who are members of the same religion,
- c. acts as an organizational clearinghouse for information between participants who have financial, physical or medical needs and participants with the present ability to pay for the benefit of those participants with present financial or medical needs. Nothing in this subparagraph shall prevent the organization from establishing qualifications of participation relating to the health of the prospective participant, nor shall it prevent the

- participants from limiting the financial or medical needs that may be eligible for payment among the participants,
- d. provides for the financial or medical needs of a participant through payments directly from one participant to another, and
 - e. suggests amounts that participants may voluntarily give with no assumption of risk or promise to pay either among the participants or between the participants and the organization. Nothing in this subparagraph shall prevent the organization from cancelling the membership of a participant if the participant indicates unwillingness to participate by failing to make a payment to another participant for a period in excess of sixty (60) days; or
12. Charitable organizations that:
- a. are described in Section 501(c)(3) of the Internal Revenue Code and Section 170(c) of the Internal Revenue Code,
 - b. issue qualified charitable gift annuity contracts,
 - c. have a minimum of One Hundred Thousand Dollars (\$100,000.00) in unrestricted assets that are exclusive of the assets comprising its qualified charitable gift annuities, and
 - d. have been in continuous operation for at least three (3) years or are successors or affiliates of a charitable organization that has been in continuous operation for at least three (3) years,

except as stated in the Oklahoma Charitable Gift Annuity Act. Added by Laws 1957, p. 216, § 110. Amended by Laws 1975, c. 334, § 1, emerg. eff. June 12, 1975; Laws 1979, c. 56, § 1, emerg. eff. April 11, 1979; Laws 1982, c. 190, § 1, operative Oct. 1, 1982; Laws 1984, c. 110, § 1, eff. Nov. 1, 1984; Laws 1988, c. 83, § 3, emerg. eff. March 25, 1988; Laws 1993, c. 34, § 1, emerg. eff. April 2, 1993; Laws 1994, c. 118, § 1, eff. Sept. 1, 1994; Laws 1996, c. 249, § 1, emerg. eff. May 28, 1996; Laws 1997, c. 418, § 2, eff. Nov. 1, 1997; Laws 1998, c. 141, § 13, emerg. eff. April 21, 1998; Laws 2008, c. 352, § 1, eff. Nov. 1, 2008.

§36-114. Existing actions, violations.

Repeal by this act of any law shall not affect or abate any right heretofore accrued, action or proceeding heretofore commenced, or any unlawful act heretofore committed under such laws and punishment or deprivation of license or authority as a consequence thereof as provided by such law, but all proceedings hereafter taken with respect thereto shall conform to the applicable provisions of

this Code insofar as possible. All such laws shall be deemed to continue in force to the extent made necessary by this provision. Laws 1957, p. 217, § 114.

§36-115. Particular provisions prevail.

Provisions of this Code relative to a particular kind of insurance or a particular type of insurer or to a particular matter shall prevail over provisions relating to insurance in general or insurers in general or to such matter in general.

Laws 1957, p. 217, § 115.

§36-117. General penalty.

In addition to any other penalty which may be applicable thereto, either under this Code or otherwise, violation of any provision of this Code shall constitute a misdemeanor and shall be punishable as such where no greater penalty is provided therefor.

Laws 1957, p. 217, § 117.

§36-121. Computation of time periods.

In computing any period of time prescribed or allowed by this title, by the rules of the Insurance Commissioner, or by any applicable statute, the day of the act, event or default from which the designated period of time begins to run shall not be included. The last day of the period so computed shall be included, unless it is a Saturday, a Sunday, a legal holiday as defined by the Oklahoma Statutes or any day when the office of the Commissioner does not remain open for public business until 4:00 p.m., in which event the period runs until the end of the next day when the office of the Commissioner is open until 4:00 p.m. When the period of time prescribed or allowed is less than seven (7) days, intermediate Saturdays, Sundays and legal holidays shall be excluded in the computation.

Added by Laws 1997, c. 418, § 3, eff. Nov. 1, 1997. Amended by Laws 2006, c. 264, § 2, eff. July 1, 2006; Laws 2021, c. 472, § 2, emerg. eff. May 11, 2021.

§36-122. Electronic filing of documents.

A. The Commissioner shall have the authority to require any entity obligated to submit or file documents with the Insurance Department to file the documents electronically.

B. The documents referred to in subsection A of this section include, but are not limited to, forms for compliance, rate filings, or annual, quarterly, or other financial statements.

C. The Commissioner may promulgate reasonable and necessary rules concerning the implementation of this section.

Added by Laws 2010, c. 222, § 1, eff. Nov. 1, 2010.

§36-123. Delivery and storage of electronic documents.

A. In this section, the following words shall have the following meanings:

1. "Delivered by electronic means" includes:

- a. delivery to an electronic mail address at which a party has consented to receive notices or documents, or
- b. posting on an electronic network or site accessible via the Internet, mobile application, computer, mobile device, tablet or any other electronic device, together with separate notice of the posting which shall be provided by electronic mail to the address at which the party has consented to receive notice, or by any other delivery method that has been consented to by the party;

2. "Health benefit plan" means a health benefit plan as defined pursuant to Section 6060.4 of this title;

3. "Party" means any recipient of any notice or document required as part of an insurance transaction, including but not limited to an applicant, an insured, a policyholder, a covered person, or an annuity contract holder; and

4. "Plan sponsor" means a person, other than a regulated entity, who establishes, adopts, or maintains a health benefit plan that covers residents of this state, including a plan established, adopted, or maintained by an employer or jointly by an employer and one or more employee organizations, an association, a committee, a joint board of trustees, or any similar group of representatives who establish, adopt, or maintain a plan.

B. Subject to the requirements of this section, any notice to a party or any other document required under applicable law in an insurance transaction, or that is to serve as evidence of insurance coverage, may be delivered, stored and presented by electronic means, so long as it meets the requirements of the Uniform Electronic Transactions Act pursuant to Section 15-101 et seq. of Title 12A of the Oklahoma Statutes.

C. Delivery of a notice or document in accordance with this section shall be considered equivalent to any delivery method required under applicable law, including delivery by first class mail; first class mail, postage prepaid; certified mail; certificate of mail; or certificate of mailing.

D. A notice or document may be delivered by electronic means by an insurer to a party under this section if:

1. The party has affirmatively consented to that method of delivery and has not withdrawn the consent; or
2. The party, before giving consent, is provided with a clear and conspicuous statement informing the party of:

- a. the right of the party to withdraw consent to have a notice or document delivered by electronic means, at any time, and any conditions or consequences imposed in the event consent is withdrawn,
- b. the types of notices and documents to which the party's consent would apply,
- c. the right of a party to have a notice or document delivered in paper form, and
- d. the procedures a party must follow to withdraw consent to have a notice or document delivered by electronic means and to update the party's electronic mail address;

3. The party:

- a. before giving consent, is provided with a statement of the hardware and software requirements for access to and retention of a notice or document delivered by electronic means, and
- b. consents electronically, or confirms consent electronically, in a manner that reasonably demonstrates that the party can access information in the electronic form that will be used for notices or documents delivered by electronic means as to which the party has given consent;

4. The insurer takes measures reasonably calculated to ensure that delivery by electronic means results in receipt of the notice or document by the party; and

5. After consent of the party is given, the insurer, in the event a change in the hardware or software requirements needed to access or retain a notice or document delivered by electronic means creates a material risk that the party will not be able to access or retain a subsequent notice or document to which the consent applies:

- a. provides the party with a statement that describes:
 - (1) the revised hardware and software requirements for access to and retention of a notice or document delivered by electronic means, and
 - (2) the right of the party to withdraw consent without the imposition of any condition or consequence that was not disclosed at the time of initial consent, and
- b. complies with paragraph 2 of this subsection.

E. 1. The plan sponsor of a health benefit plan may, on behalf of covered persons enrolled in the plan, provide consent to the mailing of all communications related to the plan by electronic means otherwise required by paragraphs 1 and 2 of subsection D of this section.

2. Before consenting on behalf of a covered person, a plan sponsor must:

- a. confirm that the covered person routinely uses electronic communications during the normal course of employment and is able to access and retain electronic communications that may be delivered by the insurer, and
- b. inform the party in any manner the plan sponsor deems appropriate that such consent will be provided, and that notices and documents related to the plan may be delivered to the party's work electronic mail address unless the party affirmatively opts out of delivery by electronic means or provides an alternative electronic mail address.

3. Before providing delivery of a notice or document by electronic means pursuant to this subsection, the insurer for the health benefit plan must:

- a. provide the party with a clear and conspicuous statement informing the person of all of the following:
 - (1) the types of notices and documents that may be delivered to the covered person by electronic means,
 - (2) the right of the party to withdraw consent to have a notice or document delivered by electronic means at any time without charge,
 - (3) the procedures the party must follow to withdraw consent to have a notice or document delivered by electronic means and to update the person's electronic mail address, and
 - (4) the right of the party to have any notice or document delivered, upon request, in paper form free of charge,
- b. provide the party opportunity to opt out of delivery by electronic means, and
- c. document that the applicable provisions of the conditions under the Uniform Electronic Transactions Act, Section 15-101 et seq. of Title 12A of the Oklahoma Statutes, are satisfied.

4. When a notice or document is provided electronically to a party pursuant to this subsection, an insurer shall apprise the party of the significance of the notice or document when it is not otherwise reasonably evident and of the right to request and obtain a paper version of such notice or document.

F. This section does not affect requirements related to content or timing of any notice or document required under applicable law.

G. If a provision of this title or applicable law requiring a notice or document to be provided to a party expressly requires

verification or acknowledgment of receipt of the notice or document, the notice or document may be delivered by electronic means only if the method used provides for verification or acknowledgment of receipt.

H. The legal effectiveness, validity or enforceability of any contract or policy of insurance executed by a party may not be denied solely because of the failure to obtain electronic consent or confirmation of consent of the party in accordance with subparagraph b of paragraph 3 of subsection D of this section.

I. 1. A withdrawal of consent by a party does not affect the legal effectiveness, validity or enforceability of a notice or document delivered by electronic means to the party before the withdrawal of consent is effective.

2. A withdrawal of consent by a party is effective within a reasonable period of time after receipt of the withdrawal by the insurer.

3. Failure by an insurer to comply with paragraph 5 of subsection D and subsection J of this section may be treated, at the election of the party, as a withdrawal of consent for purposes of this section.

J. This section does not apply to a notice or document delivered by an insurer in an electronic form before November 1, 2017, to a party who, before that date, has consented to receive notice or document in an electronic form otherwise allowed by law.

K. If the consent of a party to receive certain notices or documents in an electronic form is on file with an insurer before November 1, 2017, and pursuant to this section, an insurer intends to deliver additional notices or documents to such party in an electronic form, then prior to delivering such additional notices or documents electronically, the insurer shall:

1. Provide the party with a statement that describes:
 - a. the notices or documents that shall be delivered by electronic means under this section that were not previously delivered electronically, and
 - b. the party's right to withdraw consent to have notices or documents delivered by electronic means, without the imposition of any condition or consequence that was not disclosed at the time of initial consent; and
2. Comply with paragraph 2 of subsection D of this section.

L. An insurer shall deliver a notice or document by any other delivery method permitted by law other than electronic means if:

1. The insurer attempts to deliver the notice or document by electronic means and has a reasonable basis for believing that the notice or document has not been received by the party; or
2. The insurer becomes aware that the electronic mail address provided by the party is no longer valid.

M. Notwithstanding subsection A of this section or any other law or regulation of this state requiring an insurer to provide, send, or deliver an insurance policy or endorsement to an insured, an insurer may elect to post a policy or endorsement that does not contain personally identifiable information on its website provided it complies with all of the following:

1. The policy or endorsement is easily accessible on the website so long as it is in force;

2. The policy or endorsement is posted in a manner that enables the insured to print and save it using programs or applications widely available on the Internet and free of charge to use;

3. The insurer provides notice, in the manner it normally communicates with the insured at the time of issuance or renewal of the policy or endorsement, or at the time of any changes to the policy or endorsement, of a method by which the insured may obtain, upon request and without charge, at the choice of the insured, a paper or electronic copy of the policy or endorsement, or any changes to them, and the Internet address where the policy and endorsement are posted;

4. The insurer provides all of the following information on each declarations page, or similar document as appropriate to the line of coverage, provided to the insured at the time of issuance or renewal:

- a. a description of the exact policy and endorsement forms purchased by the insured,
- b. a method by which the insured may obtain, upon request and without charge, a paper or electronic copy of the policy or endorsement, or any changes to them,
- c. the Internet address where the policy and endorsement are posted; and

5. After expiration of the policy or endorsement, the insurer archives the expired policies or endorsements in accordance with the Oklahoma Insurance Department's general record retention requirements and makes them available upon request.

N. A producer shall not be subject to civil liability for any harm or injury that occurs as a result of a party's election to receive any notice or document by electronic means or by an insurer's failure to deliver a notice or document by electronic means.

O. This section may not be construed to modify, limit or supersede the provisions of the federal Electronic Signatures in Global and National Commerce Act, Public Law 106-229, as amended. Added by Laws 2017, c. 9, § 1, eff. Nov. 1, 2017. Amended by Laws 2024, c. 8, § 1, eff. Nov. 1, 2024; Laws 2024, c. 305, § 1, eff. Nov. 1, 2024.

§36-124. Incorporation of new measures into benefit plans.

Any measure enacted relating to a benefit plan shall be incorporated into any benefit plan that is issued or renewed on or after the effective date of the act unless specifically provided for otherwise.

Added by Laws 2022, c. 118, § 1, eff. Nov. 1, 2022.

§36-301. Insurance Department.

The Insurance Department of the State of Oklahoma is hereby created. The Insurance Commissioner shall be the chief executive officer of the Insurance Department. The powers and duties of the Insurance Commissioner shall be those created by the Oklahoma Insurance Code. The Insurance Department shall be situated in one area in the State Capitol or some other location conveniently accessible to the general public subject to the provisions of Sections 63 and 94 of Title 74 of the Oklahoma Statutes and Section 580:20-13-5 of the Oklahoma Administrative Code.

Added by Laws 1957, p. 217, § 301, operative July 1, 1957. Amended by Laws 1965, c. 60, § 2, eff. July 1, 1965; Laws 1980, c. 322, § 2, eff. Jan. 1, 1981; Laws 1986, c. 207, § 76, operative July 1, 1986; Laws 1987, c. 210, § 1, eff. July 1, 1987; Laws 1996, c. 10, § 1, emerg. eff. March 26, 1996; Laws 2006, c. 264, § 3, eff. July 1, 2006.

§36-302. Insurance Commissioner.

The Insurance Commissioner of this state shall be at least twenty-five (25) years of age and a resident of this state for at least five (5) years, and have had at least five (5) years' experience in the insurance industry in administration, sales, servicing or regulation. The Insurance Commissioner shall not be financially interested, directly or indirectly, in any insurer, agency, insurance transaction, or other entity that is regulated by the Insurance Department, except as a policyholder or claimant under a policy.

Added by Laws 1957, p. 218, § 302. Amended by Laws 1983, c. 68, § 2, eff. Nov. 1, 1983; Laws 2022, c. 178, § 1, eff. Nov. 1, 2022.

§36-302.1. Insurance Department Oklahoma City office location.

A. The Insurance Commissioner of the State of Oklahoma, in addition to the other powers and duties vested in the Commissioner, shall be authorized to relocate the Oklahoma Insurance Department's Oklahoma City offices to a single site in Oklahoma County, including but not limited to a tract of land located along the Lincoln Boulevard Corridor owned by the Commissioners of the Land Office of the State of Oklahoma, as Trustees of the Land Office Trust.

B. The new office location shall be occupied by the Oklahoma Insurance Department and shall consist of sufficient square footage to accommodate staff offices, program areas, staff conference areas,

records and computer areas, general storage areas, security equipment storage areas, main room, reception area and other necessary areas for operation of the Insurance Department.

C. The Insurance Commissioner is authorized to purchase a building, for no more than the appraised value, to serve as the new office location, or in the alternative, the Insurance Commissioner is authorized to enter into a lease-purchase agreement for the acquisition of such building with the person or entity that will develop or build the building. For the purposes of the purchase or build-out of the new office location, the Insurance Department is hereby exempted from the requirements under the Public Competitive Bidding Act of 1974 provided in Sections 101 through 139 of Title 61 of the Oklahoma Statutes, provided that no funds used for such purchase or build-out come from the General Revenue Fund, and the expenditure of all funds is overseen and approved by both the Oklahoma Insurance Department and the Commissioners of the Land Office.

Added by Laws 2018, c. 162, § 1, eff. Nov. 1, 2018.

§36-303. Official seal of Insurance Commissioner.

The Insurance Commissioner shall have an official seal, the center of which shall be the same as that of the Great Seal of the State of Oklahoma, and which shall be distinguished by the words "Insurance Commissioner - State of Oklahoma" inscribed in the circular band surrounding the remainder of the device. This seal shall be the official seal of the office. Every certificate and other document or paper duly executed by the Insurance Commissioner, authorized employees of the Insurance Department, or independent hearing examiners and all copies or photographic copies of papers certified by authority of the Commissioner and authenticated by the seal shall have the same force and effect as the original would in any suit or proceedings in any court of this state.

Added by Laws 1957, p. 218, § 303. Amended by Laws 1997, c. 418, § 4, eff. Nov. 1, 1997.

§36-304. Funds to be deposited weekly - Collection by nongovernmental entities.

A. The Insurance Commissioner shall deposit weekly with the State Treasurer all funds in the Commissioner's hands collected for the use of the state.

B. The Insurance Commissioner may contract with nongovernmental entities to collect fees and taxes on behalf of the Insurance Department.

Laws 1957, p. 218, § 304; Laws 1980, c. 159, § 4, emerg. eff. April 2, 1980; Laws 2007, c. 338, § 1, eff. July 1, 2007.

§36-305. Commissioner may appoint assistants; legal counsel.

A. The Insurance Commissioner may appoint such deputies, assistants, examiners, actuaries, attorneys, clerks and employees, at compensation to be fixed by the Insurance Commissioner, as may be necessary properly to discharge the duties imposed upon the Insurance Commissioner under this Code. The Insurance Commissioner shall appoint all examiners for the office. The attorneys appointed by the Insurance Commissioner shall be the legal advisors for the office of Insurance Commissioner and are authorized to appear for and represent the Insurance Commissioner in any and all litigation that may arise in the discharge of his or her duties except as otherwise provided elsewhere in this Code. Provided, the Insurance Commissioner, whenever the Insurance Commissioner deems it necessary, may call upon the Attorney General of the State of Oklahoma for legal counsel, and such assistance as may be required to enforce provisions of this Code.

B. No deputy, assistant or employee of the Commissioner shall be financially interested, directly or indirectly, in any insurer, agency or insurance transaction except as a policyholder or claimant under a policy; except, that as to such matters wherein a conflict of interests does not exist on the part of any such individual, the Commissioner may employ from time to time insurance actuaries or other technicians who are independently practicing their professions even though similarly employed by insurers and others. This section shall not be deemed to prohibit employment by the Commissioner of retired or pensioned personnel of insurers or insurance organizations.

Added by Laws 1957, p. 218, § 305. Amended by Laws 2017, c. 287, § 1, eff. Nov. 1, 2017.

§36-305.1. Delinquency proceedings; appointment of personnel; exemptions.

In any proceeding commenced against an insurer pursuant to Article 18 or 19 of Title 36 of the Oklahoma Statutes for the purpose of liquidating, rehabilitating, reorganizing or conserving such insurer:

1. No former employee of the Insurance Department shall be employed or appointed to serve in any capacity by the court to assist the Insurance Department for a period of one (1) year following such employee's former employment;

2. No former member of the State Legislature shall be employed to assist the Insurance Department for a period of two (2) years following the expiration of such member's service in office; and

3. If any former officer or employee of any other company has been employed to assist the Insurance Department with the said proceeding against the insurer, such other company may not purchase the assets of or acquire any other interest in said insurer for a

period of one (1) year following the expiration or termination of such officer's or employee's term of office or employment.
Amended by Laws 1987, c. 210, § 3, eff. July 1, 1987.

§36-306. Records - Disclosure.

A. The records, books, and papers pertaining to the official transactions, filings, examinations, investigations, and proceedings of the Insurance Department shall be maintained by the Department until disposition thereof has been approved by the Archives and Records Commission. These records, books, and papers shall be public records of the state. However, reports of examinations of insurers shall be filed and made public only as provided in Section 309.4 of this title. Open and ongoing investigative and disciplinary files shall not be made public until their completion or unless they are ordered to be made public by the proper judicial official. Files of the claims division of the office of the Commissioner, including but not limited to complaints and requests for assistance from insureds, and insurance agency and company records, shall not be public records and shall not be disclosed except in connection with disciplinary proceedings by the Commissioner. Final market conduct orders shall be open public records.

B. Any document or other information generated by the Insurance Department or received by the Insurance Department from a governmental agency or any other public body of any kind, including an insurance guaranty fund or risk pool board, that has a protection from disclosure under any statute or evidentiary privilege from disclosure, while in the possession of the body that generated or received the information, shall retain its confidential character while in the possession of the Insurance Department. The Insurance Department may require that any agency or public body providing a document or other information, if it expects the information to be treated confidentially by the Insurance Department, to also provide simultaneously an express reference to the claimed protection from disclosure.

C. A court shall quash any subpoena commanding the disclosure of confidential information or closed records of the Insurance Department absent a showing of justification for the disclosure.
Added by Laws 1957, p. 219, § 306, operative July 1, 1957. Amended by Laws 1980, c. 322, § 3, eff. Jan. 1, 1981; Laws 1983, c. 68, § 3, eff. Nov. 1, 1983; Laws 1985, c. 328, § 1, emerg. eff. July 29, 1985; Laws 1997, c. 418, § 5, eff. Nov. 1, 1997; Laws 2010, c. 222, § 2, eff. Nov. 1, 2010.

§36-306.1. Availability of data necessary for review - Confidentiality - Sharing of data - Definitions.

A. A supervisory agency shall make available to a requesting agency any data obtained or generated by, and in the possession of, the supervisory agency and that the requesting agency deems necessary for review in connection with the supervision of any person over which the requesting agency has direct supervisory authority. However, the requested data must relate to the person, or an affiliate of the person, over which the requesting agency has direct supervisory authority. An agency has direct supervisory authority over a person if such authority is specifically provided by statute, or the agency granted the person's charter, license, or registration, or otherwise granted permission for the person to conduct its business in this state.

B. When a requesting agency and a federal regulatory agency or self-regulatory association have concurrent jurisdiction over a person, a requesting agency may share with such agency or association data received from a supervisory agency. However, the federal regulatory agency or self-regulatory association must return such shared data to the requesting agency unless the federal regulatory agency or self-regulatory association has obtained approval from the supervisory agency to retain the data. The term "federal regulatory agency" shall not include law enforcement agencies.

C. 1. Notwithstanding any other statute, rule, or policy governing or relating to records of the requesting agency, all data received by a requesting agency from a supervisory agency shall be and remain confidential and not open to public inspection, subpoena, or any other form of disclosure while in the possession of the requesting agency. Any request for inspection, subpoena, or other form of disclosure must be directed at the supervisory agency from which the data originated and disclosure thereof shall be subject to the laws, rules, and policies governing or relating to records of the supervisory agency.

2. The provisions of data by a supervisory agency to a requesting agency under this section shall not constitute a waiver of, or otherwise affect, any privilege or claim of confidentiality that a supervisory agency may claim with respect to such data under any federal laws or laws of this state.

D. A supervisory agency is not required to share original documents with a requesting agency. A requesting agency shall reimburse the supervisory agency for costs associated with providing copies of data to the requesting agency.

E. Nothing in the Oklahoma Financial Privacy Act, Sections 2201 through 2206 of Title 6 of the Oklahoma Statutes, shall prohibit the sharing of data as described in this section. Additionally, neither a supervisory agency nor requesting agency shall be required to follow any procedure described in the Oklahoma Financial Privacy Act when sharing data as described in this section.

F. As used in this section:

1. "Affiliate" shall mean any person that controls, is controlled by, or is under common control with another person. A person shall be deemed to have "control" over any person if the person:

- a. directly or indirectly or acting through one or more other persons owns, controls, or has power to vote ten percent (10%) or more of any class of voting securities of the other person, or
- b. the person controls in any manner the election, appointment, or designation of a majority of the directors, trustees, or other managing officers of the person;

2. "Data" shall mean copies of any documents, reports, examination reports, letters, correspondence, orders, stipulations, memorandums of understanding, agreements, or any other records not open for public inspection generated by a supervisory agency or obtained by a supervisory agency from the person it supervises, whether in paper or electronic format. However, "data" shall not include records that a requesting agency receives from a supervisory agency pursuant to this section;

3. "Requesting agency" shall mean, as applicable, the Oklahoma State Banking Department, the Oklahoma Insurance Department, or the Oklahoma Department of Securities, that requests from a supervisory agency data relating to a person over which the requesting agency does not have direct supervisory authority;

4. "Supervision" shall mean any examination, assessment, order, stipulation, agreement, report, memorandum of understanding, or other regulatory matter or process that a requesting agency is authorized to perform in relation to a person; and

5. "Supervisory agency" shall mean, as applicable, the Oklahoma State Banking Department, the Oklahoma Insurance Department, or the Oklahoma Department of Securities, that maintains data relating to a person over which the agency has direct supervisory authority.

Added by Laws 2000, c. 205, § 32, emerg. eff. May 17, 2000.

§36-307. Duties of Insurance Commissioner.

The Insurance Commissioner shall be charged with the duty of administration and enforcement of the provisions of the Oklahoma Insurance Code, of any requirements placed on an insurance company pursuant to the Oklahoma Statutes. The Commissioner shall have jurisdiction over complaints against all persons engaged in the business of insurance, and shall hear all matters either in person, by authorized disinterested employees or by hearing examiners appointed by the Commissioner for that purpose and not specifically addressed otherwise in this act. It shall be the duty of the Commissioner to file and safely keep all books and papers required

by law to be filed with the Insurance Department, and to keep and preserve in permanent form a full record of proceedings including a concise statement of the conditions of such insurers and other entities reported and examined by the Department and its examiners. The Commissioner shall, annually, at the earliest practicable date after returns are received from the several authorized insurers and other organizations, make a report to the Governor of the affairs of the office of the Commissioner, which report shall contain a tabular statement and synopsis of the several statements, as accepted by the Commissioner, which shall include with respect to each insurance company the admitted assets, liabilities except capital, capital and surplus, Oklahoma premium income, amount of claims paid in Oklahoma and such other matters as may be of benefit to the public.

The Commissioner may educate consumers and make recommendations regarding the subject of insurance in this state, and shall set forth in a statement the various sums received and disbursed by the Department, from and to whom and for what purpose. Such report shall be published by and subject to the order of the Commissioner. The Commissioner shall, upon retiring from office, deliver to the qualified successor all furniture, records, papers and property of the office.

Added by Laws 1957, p. 219, § 307, operative July 1, 1957. Amended by Laws 1965, c. 60, § 3, eff. July 1, 1965; Laws 1972, c. 162, § 1, emerg. eff. April 7, 1972; Laws 1980, c. 322, § 4, eff. Jan. 1, 1981; Laws 1986, c. 207, § 77, operative July 1, 1986; Laws 1987, c. 210, § 4, eff. July 1, 1987; Laws 1997, c. 418, § 6, eff. Nov. 1, 1997; Laws 2005, c. 355, § 3, eff. Nov. 1, 2005; Laws 2006, c. 264, § 4, eff. July 1, 2006; Laws 2017, c. 362, § 1; Laws 2021, c. 472, § 3, emerg. eff. May 11, 2021; Laws 2024, c. 345, § 2, eff. Nov. 1, 2024.

§36-307.1. Rules and regulations.

The Insurance Commissioner may adopt reasonable bulletins, orders, rules and regulations for the implementation and administration of the provisions of the Insurance Code and other statutes for which the Commissioner has jurisdiction.

Added by Laws 1983, c. 89, § 14, eff. Nov. 1, 1983. Amended by Laws 2024, c. 345, § 3, eff. Nov. 1, 2024.

§36-307.2. Nonpublic personal information.

A. No person shall disclose any nonpublic personal information contrary to the provisions of Title V of the Gramm-Leach-Bliley Act of 1999, Public Law No. 106-102.

B. The Insurance Commissioner may promulgate rules necessary to carry out the provisions of this section.

C. Nothing in this section shall be construed to create a private cause of action.

Added by Laws 2001, c. 363, § 1, eff. July 1, 2001.

§36-307.3. State Insurance Commissioner Revolving Fund.

A. Effective July 1, 2009, there is hereby created in the State Treasury a revolving fund for the Insurance Commissioner called the State Insurance Commissioner Revolving Fund. The revolving fund shall be used to fund the operations of the Office of the Insurance Commissioner.

1. Notwithstanding any other law to the contrary, the revolving fund shall consist of and consolidate all funds that are or have been paid or collected by the Insurance Commissioner pursuant to the laws of this state and the rules of the Insurance Department except that the revolving fund shall not include:

- a. premium taxes,
- b. monies transferred to the Attorney General's Insurance Fraud Unit Revolving Fund pursuant to Section 362 of this title,
- c. funds paid to and collected pursuant to the Oklahoma Certified Real Estate Appraisers Act, Sections 858-700 through 858-732 of Title 59 of the Oklahoma Statutes,
- d. health carrier access payments paid to and collected by the Insurance Commissioner and deposited into the Health Carrier Access Payment Revolving Fund,
- e. recoveries obtained as a result of insurance-related crimes, and other fines, late fees, and penalties assessed and collected, and
- f. monies collected for or received from the Workers' Compensation Commission.

2. The revolving fund shall be a continuing fund, not subject to fiscal year limitations. Expenditures from the revolving fund shall be made pursuant to the laws of this state and the statutes relating to the Insurance Department. Warrants for expenditures from the revolving fund shall be drawn by the State Treasurer, based on claims signed by an authorized employee or employees of the Insurance Department and filed with the Director of the Office of Management and Enterprise Services.

B. All funds collected by the Insurance Commissioner shall be paid into the State Treasury weekly.

C. After the effective date of this act, the State Treasury is authorized and directed to deduct from the funds paid or collected by the Insurance Commissioner a sum equal to seventy-six and one-half percent (76.5%) of the payment and place the same to the credit of the General Revenue Fund of the state. The State Treasurer shall place to the credit of the State Insurance Commissioner Revolving Fund the remainder of the funds so paid and collected by the Insurance Commissioner.

Added by Laws 2009, c. 432, § 1, eff. July 1, 2009. Amended by Laws 2010, c. 222, § 3, eff. Nov. 1, 2010; Laws 2010, c. 300, § 5; Laws 2011, c. 360, § 1; Laws 2012, c. 304, § 122; Laws 2014, c. 183, § 1, eff. Nov. 1, 2014.

§36-307.4. Use of grant - Audited annually.

A. The Insurance Commissioner may solicit, accept and authorize the use of any grant made to the Insurance Department as long as the terms of the grant are carried out and the Insurance Commissioner holds the funds in trust for the purposes of carrying out the terms of the grant.

B. The Insurance Commissioner must annually account to the State Auditor and Inspector for all monies or property received or extended by virtue of this section. The account shall state:

1. The source of the monies or property received with the actual date of its receipt;
2. The particular use or place for which it was expended; and
3. The balance on hand showing the place of deposit of the unexpended balance.

Added by Laws 2009, c. 294, § 10, eff. July 1, 2009.

§36-307.5. Insurance Department Anti-Fraud Revolving Fund.

A. There is hereby created in the State Treasury a revolving fund for the Oklahoma Insurance Department, to be designated the "Insurance Department Anti-Fraud Revolving Fund". The fund shall be a continuing fund, not subject to fiscal year limitation, and shall consist of any monies designated to the fund as provided in subsections B and C of this section. Warrants for expenditures from the revolving fund shall be drawn by the State Treasurer, based on claims signed by an authorized employee or employees of the Insurance Department and filed with the Director of the Office of Management and Enterprise Services. The fund shall be used for the purpose of administering investigations of abuse, negligence or criminal conduct regarding insurance laws or regulations.

B. The Department shall deposit all of the monies obtained as a result of insurance-related crimes, and other fines, late fees, and penalties assessed and collected into the Insurance Department Anti-Fraud Revolving Fund.

C. Each year, the Department shall transfer to the General Revenue Fund the first Four Hundred Eighty-two Thousand Five Hundred Dollars (\$482,500.00) collected by the Department and deposited in the Insurance Department Anti-Fraud Revolving Fund. The next Five Hundred Thousand Dollars (\$500,000.00) collected by the Department each year shall be divided evenly between the Department and the Oklahoma Attorney General. All collections to be submitted to the Attorney General shall be deposited in the Attorney General's Insurance Fraud Unit Revolving Fund. Any collections above Nine

Hundred Eighty-two Thousand Five Hundred Dollars (\$982,500.00) shall be deposited each year into the Insurance Department Anti-Fraud Revolving Fund and shall be retained for use by the Department for the purposes of administering investigations of abuse, negligence or criminal conduct regarding insurance laws or regulations. Added by Laws 2011, c. 360, § 2. Amended by Laws 2012, c. 304, § 123.

§36-307.6. Insurance Department Pharmacy Benefits Manager Revolving Fund.

A. There is hereby created in the State Treasury a revolving fund for the Insurance Department, to be designated the "Insurance Department Pharmacy Benefits Manager Revolving Fund". The fund shall be a continuing fund, not subject to fiscal year limitation, and shall consist of any monies deposited to the fund as provided in subsection B of this section. All monies accruing to the credit of the fund are hereby appropriated and may be budgeted and expended by the Department for the purpose of licensing, regulating and investigating abuse, negligence, criminal conduct, or other violations of insurance laws and regulations, and ensuring compliance with the same. Warrants for expenditures from the revolving fund shall be drawn by the State Treasurer, based on claims signed by an authorized employee or employees of the Insurance Department, and filed with the Director of the Office of Management and Enterprise Services.

B. The Department shall deposit all the monies obtained from the licensure and regulation of pharmacy benefits managers including, but not limited to, any fees, fines, settlement or consent order proceeds, or other penalties assessed and collected into the Insurance Department Pharmacy Benefits Manager Revolving Fund created in subsection A of this act.

Added by Laws 2022, c. 6, § 1, emerg. eff. March 14, 2022. Amended by Laws 2022, c. 67, § 1, emerg. eff. April 25, 2022.

§36-308. Repealed by Laws 1991, c. 204, § 14, eff. Sept. 1, 1991.

§36-309. Repealed by Laws 1991, c. 204, § 14, eff. Sept. 1, 1991.

§36-309.1. Examinations - Definitions.

As used in Sections 309.1 through 309.7 of this title:

1. "Commissioner" means the Insurance Commissioner;
2. "Company" means any person engaging in or proposing or attempting to engage in any transaction or kind of insurance or surety business and any person or group of persons who may otherwise be subject to the administrative or regulatory authority of the Commissioner;

3. "Department" means the Insurance Department;

4. "Examiner" means any individual or firm having been authorized by the Commissioner to conduct an examination;

5. "Insurer" means every person engaged in the business of making contracts of insurance or indemnity including not-for-profit hospital service and medical indemnity corporations; and

6. "Person" means any individual, aggregation of individuals, trust, association, recognized legal entity, or any affiliate thereof.

Added by Laws 1991, c. 204, § 1, eff. Sept. 1, 1991. Amended by Laws 1997, c. 418, § 7, eff. Nov. 1, 1997.

§36-309.2. Nature and frequency of examinations - Reports in lieu of examinations.

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 a financial examination of every domestic insurer licensed in this state not less frequently than once every five (5) years. The Commissioner shall, at a minimum, conduct or cause to be conducted 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 D 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. The Commissioner may adopt rules setting forth criteria and informing domestic insurers of those factors which may contribute to the Commissioner requiring the financial examination of an insurer prior to the end of the five-year-examination requirement provided in subsection A of this section.

C. 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.

D. 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.

E. 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.

Added by Laws 1991, c. 204, § 2, eff. Sept. 1, 1991. Amended by Laws 1993, c. 79, § 1, eff. Sept. 1, 1993; Laws 1997, c. 418, § 8, eff. Nov. 1, 1997; Laws 2009, c. 176, § 1, eff. Nov. 1, 2009; Laws 2012, c. 154, § 1, eff. Nov. 1, 2012.

§36-309.3. Appointment of examiner - Compliance with examiner's requests - Powers of Commissioner.

A. Upon determining that an examination should be conducted, the Insurance Commissioner shall issue an examination warrant appointing one or more examiners to perform the examination and instructing them as to the scope of the examination. In conducting the examination, the examiner shall observe those guidelines and procedures set forth in the Examiners' Handbook adopted by the National Association of Insurance Commissioners as supplemented by rules of the Commissioner. The Commissioner may also employ such other guidelines or procedures as the Commissioner may deem appropriate.

B. Every company or person from whom information is sought, including all of its officers, directors, employees and agents, shall provide to the Commissioner and examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents, and any or all computer or other recordings relating to the property, assets, business and affairs of the company being examined. The officers, directors, employees and agents of the company or person shall facilitate such examination and aid in such examination so far as it is in their power to do so. The refusal of any company, by its officers,

directors, employees or agents, to submit to examination or to comply with any reasonable written request of the examiners shall be grounds for suspension or refusal of, or nonrenewal of any license or authority held by the company to engage in an insurance or other business subject to the Commissioner's jurisdiction. Any such proceedings for suspension, revocation or refusal of any license or authority shall be conducted pursuant to Section 619 of this title.

C. The Commissioner or examiners shall have the power to issue subpoenas, to administer oaths and to examine under oath any person as to any matter pertinent to the examination. Upon the failure or refusal of any person to obey a subpoena, the Commissioner may petition a court of competent jurisdiction, and upon proper showing, the Court may enter any order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order shall be punishable as contempt of court.

D. When making an examination under Sections 309.1 through 309.7 of this title, the Commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants or an accounting firm or individual holding a permit to practice public accounting, certified financial examiners or other professionals and specialists as examiners, the cost of which shall be borne by the company which is the subject of the examination.

E. Nothing contained in Sections 309.1 through 309.7 of this title shall be construed to limit the Commissioner's authority to terminate or suspend any examination in order to pursue other legal or regulatory action pursuant to the insurance laws of this state. Findings of fact and conclusions made in any examination report shall be prima facie evidence in any legal or regulatory action.

F. Nothing contained in Sections 309.1 through 309.7 of this title shall be construed to limit the Commissioner's authority to use and, if appropriate, to make public any final or preliminary examination report, any examiner or company workpapers or other documents, or any other information discovered or developed during the course of any examination in the furtherance of any legal or regulatory action which the Commissioner may deem appropriate.

Added by Laws 1991, c. 204, § 3, eff. Sept. 1, 1991. Amended by Laws 1997, c. 418, § 9, eff. Nov. 1, 1997.

§36-309.4. Report of examination - Review by Commissioner - Investigatory hearing - Disclosure.

A. All examination reports shall be comprised of only facts appearing upon the books, records, or other documents of the company, its agents or other persons examined, or as ascertained from the testimony of its officers or agents or other persons examined concerning its affairs, and such conclusions and recommendations as the examiners find reasonably warranted from such facts.

B. No later than thirty (30) days following completion of the examination, the examiner in charge shall file with the Insurance Department a verified written report of examination under oath. Upon receipt of the verified report, the Department shall transmit the report to the company examined, together with a notice which shall afford such company examined a reasonable opportunity of not more than twenty (20) days to make a written submission or written rebuttal with respect to any matters contained in the examination report.

C. Within twenty (20) days of the end of the period allowed for the receipt of written submissions or written rebuttals, the Insurance Commissioner shall fully consider and review the report, together with any written submissions or written rebuttals and any relevant portions of the examiners' work papers and enter an order:

1. Adopting the examination report as filed or with modification or corrections. If the examination report reveals that the company is operating in violation of any law, regulation or prior order of the Commissioner, the Commissioner may order the company to take any action the Commissioner considers necessary and appropriate to cure such violation;

2. Rejecting the examination report with directions to the examiners to reopen the examination for purposes of obtaining additional data, documentation or information, and refile pursuant to subsection A of this section; or

3. Calling for an investigatory hearing with notice pursuant to the Administrative Procedures Act to the company for purposes of obtaining additional documentation, data, information and testimony.

D. 1. All orders entered pursuant to paragraph 1 of subsection C of this section shall be accompanied by findings and conclusions resulting from the Commissioner's consideration and review of the examination report, relevant examiner work papers and any written submissions or rebuttals. Any such order shall be considered a final administrative decision and may be appealed pursuant to the Administrative Procedures Act, and shall be served upon the company by certified mail, together with a copy of the adopted examination report. Within thirty (30) days of the issuance of the adopted report, the company shall file affidavits executed by each of its directors stating under oath that they have received a copy of the adopted report and related orders.

2. Any hearing conducted pursuant to paragraph 3 of subsection C of this section by the Commissioner or authorized representative shall be conducted as a nonadversarial confidential investigatory proceeding as necessary for the resolution of any inconsistencies, discrepancies or disputed issues apparent upon the face of the filed examination report or raised by or as a result of the Commissioner's review of relevant work papers or by the written submission or rebuttal of the company. Within thirty (30) days of the conclusion

of any such hearing, the Commissioner shall enter an order pursuant to paragraph 1 of subsection C of this section.

3. The Commissioner shall not appoint an examiner as an authorized representative to conduct the hearing. The Commissioner or a representative of the Commissioner may issue subpoenas for the attendance of any witnesses or the production of any documents deemed relevant to the investigation whether under the control of the Department, the company or other persons. The documents produced shall be included in the record, and testimony taken by the Commissioner or representative of the Commissioner shall be under oath and preserved for the record.

4. Nothing contained in this section shall require the Department to disclose any information or records which would indicate or show the existence or content of any investigation or activity of a criminal justice agency.

5. The hearing shall proceed with the Commissioner or a representative of the Commissioner posing questions to the persons subpoenaed. Thereafter the company and the Department may present testimony relevant to the investigation. The company and the Department shall be permitted to make closing statements and may be represented by counsel of their choice.

E. 1. Upon the adoption of the examination report under paragraph 1 of subsection C of this section, the Commissioner shall continue to hold the content of the examination report as private and confidential information for a period of two (2) days except to the extent provided in subsection B of this section and subsection F of Section 309.3 of this title. Thereafter, the Commissioner may open the report for public inspection so long as no court of competent jurisdiction has stayed its publication.

2. Nothing contained in Sections 309.1 through 309.7 of this title shall prevent or be construed as prohibiting the Commissioner from disclosing the content of an examination report, preliminary examination report or results, or any matter relating thereto, to the insurance department of this or any other state or country, or to law enforcement officials of this or any other state or agency of the federal government at any time, so long as such agency or office receiving the report or matters relating thereto agrees in writing to hold it confidential and in a manner consistent with Sections 309.1 through 309.7 of this title.

3. In the event the Commissioner determines that regulatory action is appropriate as a result of any examination, the Commissioner may initiate any proceedings or actions as provided by law.

4. No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information provided to the Commissioner shall occur as a result of disclosure to the

Commissioner under this section or as a result of sharing as authorized in subparagraph 2 of this paragraph.

F. All working papers, recorded information, documents, data calls, Market Conduct Annual Statements and copies thereof produced by, obtained by or disclosed to the Commissioner or any other person in the course of an examination made under Sections 309.1 through 309.7 of this title, or in the course of analysis by the Commissioner or any other person of the financial condition or market conduct of a company, shall be given confidential treatment and are not subject to subpoena and may not be made public by the Commissioner or any other person, except to the extent provided in subsection E of this section and subsection F of Section 309.3 of this title. Access may also be granted to the National Association of Insurance Commissioners. Such parties shall agree in writing prior to receiving the information to provide to it the same confidential treatment as required by this section, unless the prior written consent of the company to which it pertains has been obtained.

Added by Laws 1991, c. 204, § 4, eff. Sept. 1, 1991. Amended by Laws 2001, c. 363, § 2, eff. July 1, 2001; Laws 2010, c. 356, § 1, eff. Nov. 1, 2010; Laws 2015, c. 298, § 1, eff. Nov. 1, 2015; Laws 2016, c. 73, § 1, eff. Nov. 1, 2016; Laws 2017, c. 287, § 2, eff. Nov. 1, 2017.

§36-309.5. Examiner's conflict of interest.

A. No examiner may be appointed by the Insurance Commissioner if such examiner, either directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in any person subject to examination under Sections 309.1 through 309.7 of this title. This section shall not be construed to automatically preclude an examiner from being:

1. A policyholder or claimant under an insurance policy;
2. A grantor of a mortgage or similar instrument on such examiner's residence to a regulated entity if done under customary terms and in the ordinary course of business;
3. An investment owner in shares of regulated diversified investment companies; or
4. A settlor or beneficiary of a blind trust into which any otherwise impermissible holdings have been placed.

B. Notwithstanding the requirements of this section, the Commissioner may retain from time to time, on an individual basis, qualified actuaries, an accounting firm or individual holding a permit to practice public accounting in this state, or other similar individuals who are independently practicing their professions, even though said persons may from time to time be similarly employed or retained by persons subject to examination under this act. An examiner shall disclose to the Commissioner in writing any prior or

existing personal or business relationship with any company to be examined by that examiner.

Added by Laws 1991, c. 204, § 5, eff. Sept. 1, 1991. Amended by Laws 1997, c. 418, § 10, eff. Nov. 1, 1997.

§36-309.6. Payment of charges.

Any insurer or person examined under the provisions of Sections 309.1 through 309.7 of this title shall pay the proper charges incurred in such examination, including the actual expense of the Insurance Commissioner or the expenses and compensation of an authorized representative and the expense and compensation of assistants and examiners employed therein. All expenses incurred in such examination shall be verified by affidavit and a copy shall be filed in the office of the Commissioner.

Added by Laws 1991, c. 204, § 6, eff. Sept. 1, 1991. Amended by Laws 1997, c. 418, § 11, eff. Nov. 1, 1997.

§36-309.7. Liability.

A. No cause of action shall arise nor shall any liability be imposed against the Insurance Commissioner, the Commissioner's authorized representatives, or any examiner appointed by the Commissioner for any statements made or conduct performed while carrying out the provisions of Sections 309.1 through 309.7 of this title, unless the conduct was objectively unreasonable and outside the scope of the person's duties.

B. No cause of action shall arise, nor shall any liability be imposed against any person for the act of communicating or delivering information or data to the Commissioner or the Commissioner's authorized representative or examiner pursuant to an examination made under Sections 309.1 through 309.7 of this title, if such act of communication or delivery was not a fraudulent or criminal act.

C. This section does not abrogate or modify in any way any common law or statutory privilege or immunity heretofore enjoyed by any person identified in subsection A of this section.

D. A person identified in subsection A of this section shall be entitled to an award of attorney's fees and costs if determined to be the prevailing party in a civil action arising out of activities in carrying out the provisions of Sections 309.1 through 309.7 of this title, if the court determines that the party bringing the action was not substantially justified in doing so. For purposes of this section, a proceeding is substantially justified if it had a reasonable basis in law or fact at the time that it was initiated. Added by Laws 1991, c. 204, § 7, eff. Sept. 1, 1991. Amended by Laws 1997, c. 418, § 12, eff. Nov. 1, 1997.

§36-310. Repealed by Laws 1991, c. 204, § 14, eff. Sept. 1, 1991.

§36-310.1. Repealed by Laws 1997, c. 418, § 125, eff. Nov. 1, 1997.

§36-310.2. Repealed by Laws 1997, c. 418, § 125, eff. Nov. 1, 1997.

§36-310A.1. Reporting of material acquisitions and disposition of assets or material nonrenewals, cancellations or revisions of ceded reinsurance agreements.

A. Every insurer domiciled in this state shall file a report with the Insurance Commissioner disclosing material acquisitions and dispositions of assets or material nonrenewals, cancellations or revisions of ceded reinsurance agreements unless the acquisitions and dispositions of assets or material nonrenewals, cancellations or revisions of ceded reinsurance agreements have been submitted to the Commissioner for review, approval or information purposes pursuant to other provisions of the Oklahoma Insurance Code.

B. The report required in subsection A of this section is due within fifteen (15) days after the end of the calendar month in which any of the foregoing transactions occur.

C. One complete copy of the report, including any exhibits or other attachments, shall be filed with the National Association of Insurance Commissioners.

Added by Laws 1997, c. 273, § 1, eff. July 1, 1997.

§36-310A.2. Material acquisitions or dispositions defined - Information to be disclosed in report.

A. No acquisitions or dispositions of assets need be reported pursuant to Section 1 of this act if the acquisitions or dispositions are not material. For purposes of this act, a material acquisition, or the aggregate of any series of related acquisitions during any thirty-day period, or disposition, or the aggregate of any series of related dispositions during any thirty-day period, is one that is nonrecurring and not in the ordinary course of business and involves more than five percent (5%) of the reporting insurer's total admitted assets as reported in its most recent annual statement filed with the Insurance Commissioner pursuant to Section 311 of Title 36 of the Oklahoma Statutes.

B. 1. Asset acquisitions subject to Section 1 of this act include every purchase, lease, exchange, merger, consolidation, succession or any other acquisition.

2. Asset dispositions subject to this act include every sale, lease, exchange, merger, consolidation, mortgage, hypothecation, assignment whether for the benefit of creditors or otherwise, abandonment, destruction or other disposition.

C. 1. The following information is required to be disclosed in any report of a material acquisition or disposition of assets:

a. date of the transaction,

- b. manner of acquisition or disposition,
- c. description of the assets involved,
- d. nature and amount of the consideration given or received,
- e. purpose of, or reason for, the transaction,
- f. manner by which the amount of consideration was determined, and
- g. gain or loss recognized or realized as a result of the transaction.

2. Insurers are required to report material acquisitions and dispositions on a nonconsolidated basis unless the insurer is part of a consolidated group of insurers which utilizes a pooling arrangement or one hundred percent (100%) reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer ceded substantially all of its direct and assumed business to the pool. An insurer is deemed to have ceded substantially all of its direct and assumed business to a pool if:

- a. the insurer has less than One Million Dollars (\$1,000,000.00) total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement, and
- b. the net income of the business not subject to the pooling arrangement represents less than five percent (5%) of the insurer's capital and surplus.

Added by Laws 1997, c. 273, § 2, eff. July 1, 1997.

§36-310A.3. Material nonrenewals, cancellations or revisions of ceded reinsurance agreements defined - Information to be disclosed in report.

A. 1. No nonrenewals, cancellations or revisions of ceded reinsurance agreements need be reported pursuant to Section 1 of this act if the nonrenewals, cancellations or revisions are not material. For purposes of this act, a material nonrenewal, cancellation or revision is one that affects:

- a. as respects property and casualty business, including accident and health business written by a property and casualty insurer:
 - (1) more than fifty percent (50%) of the insurer's total ceded written premium, or
 - (2) more than fifty percent (50%) of the insurer's total ceded indemnity and loss adjustment reserves,
- b. as respects life, annuity, and accident and health business: more than fifty percent (50%) of the total reserve credit taken for business ceded, on an annualized basis, as indicated in the insurer's most recent annual statement, and

- c. as respects either property and casualty or life, annuity, and accident and health business, either of the following events shall constitute a material revision which must be reported:
 - (1) an authorized reinsurer representing more than ten percent (10%) of a total cession is replaced by one or more unauthorized reinsurers, or
 - (2) previously established collateral requirements have been reduced or waived as respects one or more unauthorized reinsurers representing collectively more than ten percent (10%) of a total cession.

2. However, no filing shall be required if:

- a. as respects property and casualty business, including accident and health business written by a property and casualty insurer: the insurer's total ceded written premium represents, on an annualized basis, less than ten percent (10%) of its total written premium for direct and assumed business, or
- b. as respects life, annuity, and accident and health business: the total reserve credit taken for business ceded represents, on an annualized basis, less than ten percent (10%) of the statutory reserve requirement prior to any cession.

B. 1. The following information is required to be disclosed in any report of a material nonrenewal, cancellation or revision of ceded reinsurance agreements:

- a. effective date of the nonrenewal, cancellation or revision,
- b. the description of the transaction with an identification of the initiator thereof,
- c. purpose of, or reason for, the transaction, and
- d. if applicable, the identity of the replacement reinsurers.

2. Insurers are required to report all material nonrenewals, cancellations or revisions of ceded reinsurance agreements on a nonconsolidated basis unless the insurer is part of a consolidated group of insurers which utilizes a pooling arrangement or one hundred percent (100%) reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer ceded substantially all of its direct and assumed business to the pool. An insurer is deemed to have ceded substantially all of its direct and assumed business to a pool if:

- a. the insurer has less than One Million Dollars (\$1,000,000.00) total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement, and

- b. the net income of the business not subject to the pooling arrangement represents less than five percent (5%) of the insurer's capital and surplus.

Added by Laws 1997, c. 273, § 3, eff. July 1, 1997.

§36-311. Annual statement by companies - Annual license or certificate of authority to transact business.

A. 1. All insurers authorized to do business under the provisions of this Code shall, annually, on or before the first day of March, file with the National Association of Insurance Commissioners (NAIC), statements which shall exhibit the financial condition of insurers on the thirty-first day of December of the previous year and its business of that year. Annual statements shall be filed electronically as approved by the NAIC, along with applicable fees. Domestic insurers shall file a printed annual financial statement along with all supplement filings in the office of the Insurance Commissioner annually on or before the first day of March.

2. Foreign insurers shall file an Affidavit of Filing and Financial Statement Attestation annually on or before the first day of March. The Insurance Commissioner may require foreign insurers to file the annual financial statement in a printed format. Such document required by the Insurance Commissioner shall be due annually on or before the first day of March.

3. For good cause shown, the Insurance Commissioner may extend the time within which such statements may be filed. The statements shall be in such general form and context as approved by the National Association of Insurance Commissioners for the kinds of insurance to be reported upon, and as supplemented for additional information required by the Insurance Commissioner by rule. In addition, the statements shall be prepared in accordance with the NAIC annual statement instruction handbooks, including any supplemental filings described in the NAIC annual instruction handbook, and follow the accounting procedures and practices prescribed by the NAIC accounting practices and procedure manuals as supplemented by the Insurance Commissioner by rule. The assets and liabilities shall be computed pursuant to the most conservative method allowed by the laws of this state. Such statements shall be subscribed and sworn to by the president and secretary and other proper officers. The license or certificate of authority to transact the business of insurance in this state shall be renewed unless the Insurance Commissioner finds that the facts do not warrant renewal, and that the insurer has not fully complied with all laws applicable to the insurer. Upon initial licensure, the Commissioner shall issue a license, or certificate of authority, subject to all requirements and conditions of the law, to transact business in this state, specifying in the certificate the particular

kind or kinds of insurance it is authorized to transact. The annual statement of an insurer of a foreign country shall embrace only its business and condition in the United States, and shall be subscribed and sworn to by its resident manager or principal representative in charge of its United States business, or other officer duly authorized. Any amendments and addendums to the annual statement subsequently filed with the Commissioner shall also be filed with the National Association of Insurance Commissioners, and the insurer shall pay the applicable filing fees.

B. In the absence of actual malice, or gross negligence, members of the National Association of Insurance Commissioners, their duly authorized committees, subcommittees and task forces, their delegates, National Association of Insurance Commissioners' employees, and all others charged with the responsibility of collecting, reviewing, analyzing and disseminating the information developed from the filing of the annual statement shall be acting as agents of the Commissioner under the authority of this section and shall not be subject to civil liability for libel, slander or any other cause of action by virtue of their collection, review and analysis or disseminating of the data and information collected from the filings required under this section.

C. All financial analysis ratios and examination synopses pertaining to insurance companies, which are submitted to the Commissioner by the National Association of Insurance Commissioners' Insurance Regulatory Information System, are confidential records which shall not be available for public inspection and shall not be disclosed by the Commissioner except in receivership proceedings. Added by Laws 1957, p. 220, § 311, operative July 1, 1957. Amended by Laws 1976, c. 23, § 1, emerg. eff. March 15, 1976; Laws 1986, c. 251, § 1, eff. Nov. 1, 1986; Laws 1987, c. 175, § 1, eff. Nov. 1, 1987; Laws 1992, c. 178, § 1, eff. Sept. 1, 1992; Laws 1993, c. 79, § 2, eff. Sept. 1, 1993; Laws 1997, c. 418, § 13, eff. Nov. 1, 1997; Laws 2001, c. 363, § 3, eff. July 1, 2001; Laws 2002, c. 307, § 1, eff. Nov. 1, 2002; Laws 2003, c. 150, § 1, eff. Nov. 1, 2003; Laws 2004, c. 274, § 1, eff. July 1, 2004.

§36-311.1. Fraudulent or false statement - Failure to timely file statement - Penalty.

A. Any insurer who files with the Insurance Commissioner any statement required by this Code knowing such statement to be fraudulent and materially false, upon conviction, shall be guilty of a felony, for which the punishment shall be a fine of not to exceed Fifty Thousand Dollars (\$50,000.00). Any officer, actuary, or employee of such insurer who causes such statement to be filed, knowing the fraudulent and materially false nature thereof, upon conviction, shall be guilty of a felony, for which the punishment for each occurrence shall be a fine of not to exceed Twenty-five

Thousand Dollars (\$25,000.00), or commitment to the custody of the Department of Corrections for not less than one (1) year and not more than five (5) years or both said fine and commitment, and shall never again be permitted to act as an actuary, officer, or director of any insurer licensed to do business in this state.

B. Any insurer who fails without reasonable cause and permission of the Commissioner to timely file any statement required by this Code shall be subject, after notice and opportunity for hearing, to censure, suspension or revocation of certificate. Annual statements filed after the first day of March without express written advance permission of the Commissioner shall be accompanied by a late filing fee in the amount of Two Hundred Fifty Dollars (\$250.00) or One Hundred Dollars (\$100.00) per day, whichever is greater. Repeated willful violations, after notice and opportunity for hearing, may subject the insurer to both censure, suspension, or revocation of certificate and civil penalty of not less than One Hundred Dollars (\$100.00) nor more than Ten Thousand Dollars (\$10,000.00) for each occurrence in addition to the late filing fee.

C. Prosecution or administrative action for any violation of the provisions of this section shall be commenced within four (4) years after the violation is discovered.

Added by Laws 1957, p. 221, § 311.1, operative July 1, 1957.

Amended by Laws 1983, c. 68, § 4, eff. Nov. 1, 1983; Laws 1985, c. 328, § 2, emerg. eff. July 29, 1985; Laws 1986, c. 251, § 2, emerg. eff. June 13, 1986; Laws 1993, c. 270, § 36, eff. Sept. 1, 1993; Laws 1997, c. 418, § 14, eff. Nov. 1, 1997; Laws 2009, c. 432, § 2, eff. July 1, 2009.

NOTE: Laws 1997, c. 133, § 444 repealed by Laws 1999, 1st Ex. Sess., c. 5, § 452, eff. July 1, 1999.

NOTE: Laws 1998, 1st Ex. Sess., c. 2, § 23 amended the effective date of Laws 1997, c. 133, § 444 from July 1, 1998, to July 1, 1999.

§36-311.2. Reports on financial condition.

A. The Insurance Commissioner may request financial information more frequently than quarterly if it appears an insurer is having financial difficulty, if erratic changes are occurring in the financial data of the company, if a considerable number of consumer complaints have been received, or if one or more transactions have occurred which appear to jeopardize the welfare of the policyholders. The insurer also may be requested to furnish a plan of action to improve its underwriting performance.

B. Any insurer upon request of the Commissioner shall furnish to the Insurance Commissioner within forty-five (45) days following the close of any calendar quarter, except the fourth quarter, on blank forms prescribed by the Insurance Commissioner, a statement which shall exhibit the financial condition of the company as of the last date of the month immediately preceding reporting date. Such

reports for information purposes shall contain a complete listing of all written commitments to loan, guaranties of loans, or contractual obligations concerning loans or conditional liabilities to borrowers or lenders made during the quarter reported. Such reports may require the inclusion of an exhibit of the operating results of the company for the three (3) months' period immediately preceding the date for which the financial condition is shown. A completed blank form prescribed by the Commissioner for said statement shall be furnished by each insurer for each such reporting date. Such statements shall be subscribed and sworn to by the president and the secretary and other proper officers of the company. Failure of any insurer to execute and file such statements or exhibits as required herein shall constitute cause, after notice and hearing, for censure, suspension, or revocation of certificate of authority to transact an insurance business in this state or a fine of not less than One Hundred Dollars (\$100.00) nor more than One Thousand Dollars (\$1,000.00) for each occurrence, or both censure, suspension, or revocation, and fine. The Commissioner shall set such cause for hearing and if he finds that the facts warrant, he shall order said censure, suspension, or revocation of the certificate of authority of the insurer found to be in default or said fine, or both said censure, suspension, or revocation, and fine. Willful violations, after notice and hearing, may subject the insurer to both censure, suspension or revocation of certificate and a fine of not less than One Hundred Dollars (\$100.00) or not more than Five Thousand Dollars (\$5,000.00) for each violation. The Insurance Commissioner may establish rules or regulations to carry out the purposes of this section.

Added by Laws 1970, c. 108, § 1, operative Sept. 30, 1970. Amended by Laws 1974, c. 264, § 4, emerg. eff. May 29, 1974; Laws 1983, c. 68, § 5, eff. Nov. 1, 1983; Laws 1985, c. 328, § 3, emerg. eff. July 29, 1985; Laws 1986, c. 251, § 3, emerg. eff. June 13, 1986; Laws 2002, c. 307, § 2, eff. Nov. 1, 2002.

§36-311.3. Financial reports regarding real property.

In all financial reports of an insurer to the Insurance Commissioner, real property acquired by the insurer shall be entered as an asset on the basis of its original cost along with appropriate adjustments, or the appraised market value where it is expressly indicated that such amount is based on the appraised market value and such appraisal has approval of the Insurance Commissioner. Laws 1972, c. 151, § 1, eff. Oct. 1, 1972.

§36-311.4. Annual statements reporting market conduct data of insurers - Adoption of rules - Filing fee - Use of documents.

A. Insurers authorized to do business under the provisions of the Oklahoma Insurance Code shall annually 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 (NAIC), 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 and deadlines 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 only if, prior to sharing of the market conduct annual statements, amendments, addendums to such statements or market conduct data taken from such statements, the National Association of Insurance Commissioners enters into a written agreement with the Insurance Commissioner to maintain the confidentiality of the shared information.

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 due at the time of filing, in accordance with NAIC filing deadlines.

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 this title.

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 this title, 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.

G. For any violation of this section, the Insurance Commissioner may, after notice and opportunity for a hearing, subject an insurer to a civil penalty of up to One Thousand Dollars (\$1,000.00) for each occurrence. The civil penalty may be enforced in the same manner in which civil judgments may be enforced. Added by Laws 2009, c. 176, § 2, eff. Nov. 1, 2009. Amended by Laws 2014, c. 275, § 1, eff. Nov. 1, 2014; Laws 2021, c. 180, § 1, eff. Nov. 1, 2021.

§36-311A.1. Short title - Oklahoma Annual Financial Report Act.

Sections 311A.1 through 311A.18 of this title shall be known as and may be cited as the "Oklahoma Annual Financial Report Act".

Added by Laws 2009, c. 176, § 3, eff. Nov. 1, 2009. Amended by Laws 2019, c. 28, § 1, eff. Nov. 1, 2019.

§36-311A.2. Purpose of act.

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 311A.3 of this title 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 311A.4 through 311A.13 of this title 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 311A.4, 311A.11 and 311A.12 of this title, 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 311A.10 of this title.

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.

Added by Laws 2009, c. 176, § 4, eff. Nov. 1, 2009. Amended by Laws 2019, c. 28, § 2, eff. Nov. 1, 2019.

§36-311A.3. Definitions.

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, the internal audit function of an insurer or group of insurers, if applicable, and external 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 G of Section 311A.14 of this title. 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 311A.5 of this title;

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 E of Section 311A.14 of this title;

7. "Insurer" means a licensed insurer as defined in Section 103 of this title. 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 audit function" means a person or persons that provide independent, objective and reasonable assurance designed to add value and improve an organization's operations and accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes;

10. "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 311A.5 of this title 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 311A.5 of this title 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 311A.5 of this title;

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

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

13. "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

14. "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).

Added by Laws 2009, c. 176, § 5, eff. Nov. 1, 2009. Amended by Laws 2019, c. 28, § 3, eff. Nov. 1, 2019.

§36-311A.4. Annual audit - Extensions.

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.

Added by Laws 2009, c. 176, § 6, eff. Nov. 1, 2009.

§36-311A.5. Contents of annual audited financial report.

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.
Added by Laws 2009, c. 176, § 7, eff. Nov. 1, 2009.

§36-311A.6. Registration of the name and address of the accountant or accounting firm retained to conduct the annual audit - Accountant letter - Notification of dismissal or resignation.

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.

Added by Laws 2009, c. 176, § 8, eff. Nov. 1, 2009.

§36-311A.7. Qualified independent certified public accountants.

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.

Added by Laws 2009, c. 176, § 9, eff. Nov. 1, 2009.

§36-311A.8. Audited consolidated or combined financial statements.

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.

Added by Laws 2009, c. 176, § 10, eff. Nov. 1, 2009.

§36-311A.9. Conduct of audit of financial statements.

Financial statements furnished pursuant to Section 311A.5 of this title 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 311A.16 of this title, 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. Added by Laws 2009, c. 176, § 11, eff. Nov. 1, 2009. Amended by Laws 2019, c. 28, § 4, eff. Nov. 1, 2019.

§36-311A.10. Reporting of determinations that insurer has materially misstated its financial condition - Liability - Subsequent awareness.

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-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.

Added by Laws 2009, c. 176, § 12, eff. Nov. 1, 2009.

§36-311A.11. Reporting unremediated material weaknesses of internal controls - Description of remedial actions.

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 311A.2 of this title 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.

Added by Laws 2009, c. 176, § 13, eff. Nov. 1, 2009. Amended by Laws 2019, c. 28, § 5, eff. Nov. 1, 2019.

§36-311A.12. Accountant letter to insurer - Contents.

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 American Institute of Certified Public Accountants (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 311A.13 of this title and that the accountant consents and agrees to make available for review by the Commissioner the work papers, as defined in Section 311A.13 of this title;

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 311A.7 of this title.

Added by Laws 2009, c. 176, § 14, eff. Nov. 1, 2009. Amended by Laws 2019, c. 28, § 6, eff. Nov. 1, 2019.

§36-311A.13. Work papers - Availability for examiner review - Copies.

A. Work papers 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. Work papers, 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 work papers 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 work papers 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 Commissioner or Insurance Department examiners, it shall be agreed that photocopies of pertinent audit work papers may be made and retained by the Insurance Department. Such reviews by the Commissioner or Insurance Department examiners shall be considered investigations and all working papers, recorded information, documents, copies thereof and communications obtained during the course of such investigations shall be afforded the same confidentiality as other examination work papers generated by the Insurance Department pursuant to subsection F of Section 309.4 of this title.

Added by Laws 2009, c. 176, § 15, eff. Nov. 1, 2009. Amended by Laws 2010, c. 356, § 2, eff. Nov. 1, 2010.

§36-311A.14. Audit committee - Membership - Duties.

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. The audit committee of an insurer or group of insurers shall be responsible for overseeing the insurer's internal audit function and granting the person or persons performing the function suitable authority and resources to fulfill their responsibilities if required by Section 311A.14 of this title.

D. 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 G of this section and paragraph 3 of Section 311A.3 of this title.

E. 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.

F. 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 (1) year from the occurrence of the event that caused the member to be no longer independent.

G. 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.

H. 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.

I. 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); or

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).

J. 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.

K. 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.

L. 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 National Association of Insurance Commissioners (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. Added by Laws 2009, c. 176, § 16, eff. Nov. 1, 2009. Amended by Laws 2019, c. 28, § 7, eff. Nov. 1, 2019.

§36-311A.14.1. Internal audit function requirements - Exemptions.

A. Exemption - An insurer is exempt from the requirements of this section if:

1. The insurer has annual direct written and unaffiliated assumed premium, including international direct and assumed premium, but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program less than Five Hundred Million Dollars (\$500,000,000.00); or

2. If the insurer is a member of a group of insurers that has annual direct written and unaffiliated assumed premium, including international direct and assumed premium, but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than One Billion Dollars (\$1,000,000,000.00).

B. Function - The insurer or group of insurers shall establish an internal audit function providing independent, objective and reasonable assurance to the audit committee and insurer management regarding the insurer's governance, risk management and internal controls. This assurance shall be provided by performing general and specific audits, reviews and tests and by employing other techniques deemed necessary to protect assets, evaluate control effectiveness and efficiency and evaluate compliance with policies and regulations.

C. Independence - In order to ensure that internal auditors remain objective, the internal audit function must be organizationally independent. Specifically, the internal audit function will not defer ultimate judgment on audit matters to others, and shall appoint an individual to head the internal audit function who will have direct and unrestricted access to the board of directors. Organizational independence does not preclude dual-reporting relationships.

D. Reporting - The head of the internal audit function shall report to the audit committee regularly, but no less than annually, on the periodic audit plan, factors that may adversely impact the internal audit function's independence or effectiveness, material findings from completed audits and the appropriateness of corrective actions implemented by management as a result of audit findings.

E. Additional Requirements - If an insurer is a member of an insurance holding company system or included in a group of insurers, the insurer may satisfy the internal audit function requirements set forth in this section at the ultimate controlling parent level, an intermediate holding company level or the individual legal entity level.

F. Upon written request and with good cause shown, the Insurance Commissioner may grant an exemption from the internal audit function.

Added by Laws 2019, c. 28, § 8, eff. Nov. 1, 2019.

§36-311A.15. Unlawful misleading statements - Manipulating accountant.

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.

Added by Laws 2009, c. 176, § 17, eff. Nov. 1, 2009.

§36-311A.16. Report of the insurer's internal control over financial reporting.

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 311A.11 of this title. 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 311A.5 of this title 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 311A.5 of this title 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 insurers' 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.

Added by Laws 2009, c. 176, § 18, eff. Nov. 1, 2009. Amended by Laws 2019, c. 28, § 9, eff. Nov. 1, 2019.

§36-311A.17. Exemptions from compliance - Effective dates.

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 shall comply with the Oklahoma Annual Financial Report Act each year 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. File with the Commissioner an audited financial report; and
2. Each year 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 each year unless the Commissioner permits otherwise.

E. The requirements of subsection D of Section 311A.7 of this title shall be in effect for audits of each year.

F. An insurer or group of insurers, not required to have independent audit committee members or only required to have a majority of independent audit committee members, due to the total written and assumed premium being below the threshold, shall have one (1) year following the year the threshold is exceeded 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. An insurer or group of insurers, not required to file a report because the total written premium is below the threshold, which subsequently becomes subject to the reporting requirements, shall have two (2) years following the year the threshold is exceeded 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.

H. If an insurer or group of insurers that is exempt from the requirements of Section 8 of this act no longer qualifies for that exemption, it shall have one (1) year after the year the threshold is exceeded to comply with the requirements of this act.

Added by Laws 2009, c. 176, § 19, eff. Nov. 1, 2009. Amended by Laws 2010, c. 222, § 4, eff. Nov. 1, 2010; Laws 2019, c. 28, § 10, eff. Nov. 1, 2019.

§36-311A.18. Canadian and British insurers - Letter of conformity.

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 311A.6 of this title 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 311A.4 of this title and shall affirm that the opinion expressed is in conformity with those requirements.

Added by Laws 2009, c. 176, § 20, eff. Nov. 1, 2009. Amended by Laws 2019, c. 28, § 11, eff. Nov. 1, 2019.

§36-312. Repealed by Laws 1997, c. 418, § 125, eff. Nov. 1, 1997.

§36-312.1. Report, disbursement and appropriation of fees and taxes - Record and statement - Annual reports.

A. For the fiscal year ending June 30, 2004, the Insurance Commissioner shall report and disburse one hundred percent (100%) of the fees and taxes collected under Section 624 of this title to the State Treasurer to be deposited to the credit of the Education Reform Revolving Fund of the State Department of Education. The Insurance Commissioner shall keep an accurate record of all such funds and make an itemized statement and furnish same to the State Auditor and Inspector, as to all other departments of this state.

The report shall be accompanied by an affidavit of the Insurance Commissioner or the Chief Clerk of such office certifying to the correctness thereof.

B. The Insurance Commissioner shall apportion an amount of the taxes and fees received from Section 624 of this title, which shall be at least One Million Two Hundred Fifty Thousand Dollars (\$1,250,000.00) each year, but which shall also be computed on an annual basis by the Commissioner as the amount of insurance premium tax revenue loss attributable to the provisions of subsection H of Section 625.1 of this title and increased if necessary to reflect the annual computation, and which shall be apportioned before any other amounts, as follows:

1. The following amounts shall be paid to the Oklahoma Firefighters Pension and Retirement Fund in the manner provided for in Sections 49-119, 49-120 and 49-123 of Title 11 of the Oklahoma Statutes:

Fiscal Year	Amount
FY 2006 through FY 2020	65.0%
FY 2021 as follows:	
a. for the month beginning July 1, 2020, through the month ending August 31, 2020	65.0%
b. for the month beginning September 1, 2020, through the month ending June 30, 2021	45.5%
FY 2022 and each fiscal year thereafter	65.0%;

2. The following amounts shall be paid to the Oklahoma Police Pension and Retirement System pursuant to the provisions of Sections 50-101 through 50-136 of Title 11 of the Oklahoma Statutes:

Fiscal Year	Amount
FY 2006 through FY 2020	26.0%
FY 2021 as follows:	
a. for the month beginning July 1, 2020, through the month ending August 31, 2020	26.0%
b. for the month beginning September 1, 2020, through the month ending June 30, 2021	18.2%
FY 2022 and each fiscal year thereafter	26.0%;

3. The following amounts shall be paid to the Law Enforcement Retirement Fund:

Fiscal Year	Amount
FY 2006 through FY 2020	9.0%
FY 2021 as follows:	
a. for the month beginning July 1, 2020, through the month ending August 31, 2020	9.0%

b. for the month beginning September 1, 2020, through the month ending June 30, 2021 6.3%

FY 2022 and each fiscal year thereafter 9.0%; and

4. The following amounts shall be paid to the Education Reform Revolving Fund of the State Department of Education:

Fiscal Year	Amount
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FY 2021 as follows:

for the month beginning September 1, 2020, through the month ending June 30, 2021	30.0%.
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C. After the apportionment required by subsection B of this section, for the fiscal years beginning July 1, 2004, and ending June 30, 2009, the Insurance Commissioner shall report and disburse all of the fees and taxes collected under Section 624 of this title and Section 2204 of this title, and the same are hereby apportioned as follows:

1. Thirty-four percent (34%) of the taxes collected on premiums shall be allocated and disbursed for the Oklahoma Firefighters Pension and Retirement Fund, in the manner provided for in Sections 49-119, 49-120 and 49-123 of Title 11 of the Oklahoma Statutes;

2. Seventeen percent (17%) of the taxes collected on premiums shall be allocated and disbursed to the Oklahoma Police Pension and Retirement System pursuant to the provisions of Sections 50-101 through 50-136 of Title 11 of the Oklahoma Statutes;

3. Six and one-tenth percent (6.1%) of the taxes collected on premiums shall be allocated and disbursed to the Law Enforcement Retirement Fund; and

4. All the balance and remainder of the taxes and fees provided in Section 624 of this title shall be paid to the State Treasurer to the credit of the General Revenue Fund of the state to provide revenue for general functions of state government. The Insurance Commissioner shall keep an accurate record of all such funds and make an itemized statement and furnish same to the State Auditor and Inspector, as to all other departments of this state. The report shall be accompanied by an affidavit of the Insurance Commissioner or the Chief Clerk of such office certifying to the correctness thereof.

D. After the apportionment required by subsection B of this section, the Insurance Commissioner shall report and disburse all of the fees and taxes collected under Section 624 of this title and Section 2204 of this title, and the same are hereby apportioned as follows:

1. Of the taxes collected on premiums the following shall be allocated and disbursed for the Oklahoma Firefighters Pension and Retirement Fund, in the manner provided for in Sections 49-119, 49-120 and 49-123 of Title 11 of the Oklahoma Statutes:

Fiscal Year	Amount
FY 2006 through FY 2020	36.0%
FY 2021 as follows:	
a. for the month beginning July 1, 2020, through the month ending August 31, 2020	36.0%
b. for the month beginning September 1, 2020, through the month ending June 30, 2021	25.2%
FY 2022	36.0%
FY 2023 through FY 2027	37.8%
FY 2028 and each fiscal year thereafter	36.0%;

2. Of the taxes collected on premiums the following shall be allocated and disbursed to the Oklahoma Police Pension and Retirement System pursuant to the provisions of Sections 50-101 through 50-136 of Title 11 of the Oklahoma Statutes:

Fiscal Year	Amount
FY 2006 through FY 2020	14.0%
FY 2021 as follows:	
a. for the month beginning July 1, 2020, through the month ending August 31, 2020	14.0%
b. for the month beginning September 1, 2020, through the month ending June 30, 2021	9.8%
FY 2022	14.0%
FY 2023 through FY 2027	14.7%
FY 2028 and each fiscal year thereafter	14.0%;

3. Of the taxes collected on premiums the following shall be allocated and disbursed to the Law Enforcement Retirement Fund:

Fiscal Year	Amount
FY 2006 through FY 2020	5.0%
FY 2021 as follows:	
a. for the month beginning July 1, 2020, through the month ending August 31, 2020	5.0%
b. for the month beginning September 1, 2020, through the month ending June 30, 2021	3.5%
FY 2022	5.0%
FY 2023 through FY 2027	5.25%
FY 2028 and each fiscal year thereafter	5.0%;

4. The following amounts shall be paid to the Education Reform Revolving Fund of the State Department of Education:

Fiscal Year	Amount
FY 2021 as follows:	

for the month beginning September 1,
2020, through the month ending June 30,
2021

16.5%;

5. In addition to the allocations made pursuant to paragraphs 1, 2 and 3 of this subsection, of the taxes collected on premiums the following amounts shall be allocated and disbursed annually for FY 2023 through FY 2027:

- a. Forty Thousand Six Hundred Twenty-five Dollars (\$40,625.00) to the Oklahoma Firefighters Pension and Retirement Fund,
- b. Sixteen Thousand Two Hundred Fifty Dollars (\$16,250.00) to the Oklahoma Police Pension and Retirement System, and
- c. Five Thousand Six Hundred Twenty-five Dollars (\$5,625.00) to the Oklahoma Law Enforcement Retirement Fund; and

6. All the balance and remainder of the taxes and fees provided in Section 624 of this title shall be paid to the State Treasurer to the credit of the General Revenue Fund of the state to provide revenue for general functions of state government. The Insurance Commissioner shall keep an accurate record of all such funds and make an itemized statement and furnish same to the State Auditor and Inspector, as to all other departments of this state. The report shall be accompanied by an affidavit of the Insurance Commissioner or the Chief Clerk of such office certifying to the correctness thereof.

E. The disbursements provided for in subsections A, B, C and D of this section shall be made monthly. The Insurance Commissioner shall report annually to the Governor, the Speaker of the House of Representatives, the President Pro Tempore of the Senate and the State Auditor and Inspector, the amounts collected and disbursed pursuant to this section.

F. Notwithstanding any other provision of law to the contrary, no tax credit authorized by law enacted on or after July 1, 2008, which may be used to reduce any insurance premium tax liability shall be used to reduce the amount of insurance premium tax revenue apportioned to the Oklahoma Firefighters Pension and Retirement System, the Oklahoma Police Pension and Retirement System, the Oklahoma Law Enforcement Retirement System or the Education Reform Revolving Fund.

Added by Laws 1957, p. 221, § 312.1, operative July 1, 1957.

Amended by Laws 1957, p. 632, § 3, emerg. eff. May 31, 1957; Laws 1959, p. 133, § 1, emerg. eff. July 8, 1959; Laws 1963, c. 316, § 1, emerg. eff. June 19, 1963; Laws 1967, c. 43, § 1, emerg. eff. March 29, 1967; Laws 1969, c. 132, § 1, eff. July 1, 1969; Laws 1972, c. 58, § 1, emerg. eff. March 21, 1972; Laws 1975, c. 34, § 1, emerg. eff. March 25, 1975; Laws 1979, c. 30, § 10, emerg. eff. April 6,

1979; Laws 1981, c. 6, § 1, emerg. eff. March 19, 1981; Laws 1988, c. 83, § 4, emerg. eff. March 25, 1988; Laws 2003, c. 315, § 1, eff. July 1, 2003; Laws 2004, c. 368, § 54, eff. July 1, 2004; Laws 2005, c. 381, § 1, eff. July 1, 2006; Laws 2006, 2nd Ex. Sess., c. 46, § 17, eff. July 1, 2006; Laws 2008, c. 436, § 1, eff. July 1, 2009; Laws 2013, c. 165, § 5, eff. Nov. 1, 2013; Laws 2020, c. 16, § 1, eff. Sept. 1, 2020; Laws 2021, c. 489, § 1, eff. July 1, 2021.

§36-312A. Enforcement and recording of penalties and fees.

Civil penalties and fees imposed by the Insurance Commissioner pursuant to Oklahoma law may be enforced in the same manner in which civil judgments may be enforced. All final orders of the Insurance Commissioner imposing administrative charges, fees, civil penalties, restitution or fines may be recorded in the office of the Clerk of the District Court of Oklahoma County and, upon such recording, all appropriate writs and process shall issue and shall be enforced by the judges of said court upon application.

Added by Laws 1997, c. 418, § 15, eff. Nov. 1, 1997. Amended by Laws 2006, c. 264, § 5, eff. July 1, 2006; Laws 2015, c. 298, § 2, eff. Nov. 1, 2015; Laws 2021, c. 472, § 4, emerg. eff. May 11, 2021; Laws 2024, c. 345, § 4, eff. Nov. 1, 2024.

§36-313. Requirements for orders and notices - Final agency action - Applicability of Administrative Procedures Act.

A. Orders and notices of the Insurance Commissioner shall be in writing and shall be signed by the Commissioner, an authorized employee of the Insurance Department, or an independent hearing examiner. A final order signed by an independent hearing examiner, after hearing, shall be final agency action, notwithstanding the provisions of Section 311 of Title 75 of the Oklahoma Statutes.

B. In the exercise of the powers and the performance of the duties enumerated in this title, the Commissioner shall comply with the procedures of the Administrative Procedures Act. Any conflict between the provisions of Title 75 of the Oklahoma Statutes and of this title shall be resolved in favor of the provisions of this title.

Added by Laws 1957, p. 222, § 313, operative July 1, 1957. Amended by Laws 1987, c. 175, § 2, eff. Nov. 1, 1987; Laws 1997, c. 418, § 16, eff. Nov. 1, 1997; Laws 2006, c. 264, § 6, eff. July 1, 2006; Laws 2021, c. 472, § 5, emerg. eff. May 11, 2021; Laws 2024, c. 345, § 5, eff. Nov. 1, 2024.

§36-314. Repealed by Laws 1997, c. 418, § 125, eff. Nov. 1, 1997.

§36-315. Repealed by Laws 1997, c. 418, § 125, eff. Nov. 1, 1997.

§36-316. Repealed by Laws 1997, c. 418, § 125, eff. Nov. 1, 1997.

§36-317. Witnesses or evidence.

A. The Insurance Commissioner may take depositions, subpoena witnesses or documentary evidence, administer oaths, and examine under oath any individual relative to the affairs of any person being examined, or relative to the subject of any hearing or investigation.

B. All administrative subpoenas shall be served in the same manner as if issued from a district court or in accordance with the Administrative Procedures Act. If any person fails to obey a subpoena lawfully served, the Commissioner may forthwith report such disobedience, together with a copy of the subpoena and proof of service thereof, to the district court of the county in which the person was required to appear, and such court shall forthwith cause such person to be produced and shall impose penalties as though the person had disobeyed a subpoena issued out of such court.

Added by Laws 1957, p. 223, § 317. Amended by Laws 1997, c. 418, § 17, eff. Nov. 1, 1997.

NOTE: Laws 1997, c. 133, § 445 repealed by Laws 1999, 1st Ex.Sess., c. 5, § 452, eff. July 1, 1999.

NOTE: Laws 1998, 1st Ex.Sess., c. 2, § 23 amended the effective date of Laws 1997, c. 133, § 445 from July 1, 1998, to July 1, 1999.

§36-318. Repealed by Laws 1997, c. 418, § 125, eff. Nov. 1, 1997.

§36-319. Appointment of independent hearing examiner - Fees - Time period for issuance of final order.

In conducting any hearing pursuant to the Insurance Code, the Insurance Commissioner may appoint an independent hearing examiner who shall sit as a quasi-judicial officer. The ordinary fees and costs of such hearing examiner shall be assessed by the hearing examiner against the respondent, unless the respondent is the prevailing party. Within thirty (30) days after termination of the hearing or of any rehearing thereof or reargument thereon, unless such time is extended by stipulation, a final order shall be issued.

Added by Laws 1957, p. 224, § 319, operative July 1, 1957. Amended by Laws 1987, c. 175, § 3, eff. Nov. 1, 1987; Laws 1997, c. 418, § 18, eff. Nov. 1, 1997; Laws 2021, c. 472, § 6, emerg. eff. May 11, 2021; Laws 2024, c. 345, § 6, eff. Nov. 1, 2024.

§36-320. Judicial review.

A. Any person aggrieved by a final order of the Insurance Commissioner may obtain judicial review in accordance with the Administrative Procedures Act. The venue of any such action shall be in the district court of Oklahoma County. A copy of such petition shall also forthwith be served upon the Insurance Commissioner and other parties in interest, if any, and the

Insurance Commissioner shall thereupon certify and file in such court a transcript of the record of such hearing and a copy of the order appealed from.

B. Upon filing of the petition the court shall have full jurisdiction, and shall determine whether such filing shall operate as a stay of the order appealed from.

Added by Laws 1957, p. 224, § 320. Amended by Laws 1997, c. 418, § 19, eff. Nov. 1, 1997.

§36-321. Fees and licenses - Deposits.

A. The Insurance Commissioner shall collect in advance the following fees:

1. For filing charter documents:
Original charter documents,
articles of incorporation, bylaws,
or record of organization of alien
or foreign insurers, or certified
copies thereof.....\$50.00
2. Certificate of Authority or Certificate of Approval:
 - (a) Issuance:
.....\$150.00
 - (b) Renewal:
.....\$150.00
3. For filing appointment of Insurance
Commissioner as agent for service
of process.....\$10.00
4. Miscellaneous:
 - (a) Copies of records, per page.....\$0.40
 - (b) Amended charter documents,
articles of incorporation or
bylaws of domestic, alien or
foreign insurers or health
maintenance organizations.....\$50.00
 - (c) Certificate of Commissioner,
under seal.....\$5.00
 - (d) For filing Merger and
Acquisition Forms (Domestic
Insurers).....\$1,000.00
 - (e) For filing Variable Product
Forms.....\$200.00
 - (f) For filing a Life, Accident
and Health Policy and Health
Maintenance Organization
contract.....\$50.00
 - (g) For filing an advertisement or
rider application to a Life,
Accident and Health Policy and

- Health Maintenance Organization contract.....\$25.00
- (h) Pending Company Review.....\$1,000.00
- (i) For filing a Viatical Settlement Contract or Life Settlement.....\$50.00
- (j) For filing an advertisement for Viatical Settlement or Life Settlement.....\$25.00
- (k) For filing application for Viatical Settlement or Life Settlement Contract.....\$25.00
- (l) Miscellaneous form filing.....\$25.00

B. There shall be assessed an annual fee of Five Hundred Dollars (\$500.00) payable by each insurer, health maintenance organization, fraternal benefit society, hospital service and medical indemnity corporation, or charitable and benevolent corporation licensed to do business in this state, or United States surplus lines insurance companies approved to do business in this state, to pay for the filing, processing, and reviewing of financial statements by personnel of the Office of the State Insurance Commissioner.

Added by Laws 1957, p. 224, § 321, operative July 1, 1957. Amended by Laws 1965, c. 60, § 6, eff. July 1, 1965; Laws 1967, c. 389, § 1, emerg. eff. May 23, 1967; Laws 1968, c. 244, § 1, emerg. eff. April 24, 1968; Laws 1969, c. 84, § 1, emerg. eff. March 18, 1969; Laws 1977, c. 202, § 4, emerg. eff. June 14, 1977; Laws 1980, c. 164, § 14, emerg. eff. April 15, 1980; Laws 1983, c. 68, § 7, eff. Nov. 1, 1983; Laws 1985, c. 328, § 4, eff. July 29, 1985; Laws 1990, c. 258, § 79, operative July 1, 1990; Laws 1992, c. 65, § 1, eff. Sept. 1, 1992; Laws 1993, c. 270, § 37, eff. Sept. 1, 1993; Laws 1994, c. 129, § 1, eff. Sept. 1, 1994; Laws 2002, c. 307, § 3, eff. Nov. 1, 2002; Laws 2004, c. 274, § 2, eff. July 1, 2004; Laws 2009, c. 432, § 3, eff. July 1, 2009; Laws 2014, c. 275, § 2, eff. Nov. 1, 2014; Laws 2018, c. 95, § 1, eff. Nov. 1, 2018.

§36-321.1. Report fees - Information requests - Costs.

A. There shall be collected at the time of filing of a report, a fee payable by each insurer required to file a report under Section 101 et seq. of this title, provided the insurer's total written premium per liability category exceeds the requisite filing fee, which shall be Four Hundred Dollars (\$400.00) for each periodic claims report required by Section 1250.9 of this title.

B. All public requests for information provided by this act shall be in writing. All requests for copying such data shall be in writing and may be provided to the requestor after such reasonable time to process such copying and shall be at such costs as provided

in Section 321 of this title or, if computerized printouts are necessary, at such reasonable costs as established by the Commissioner, or if such items cannot be reproduced by the Commissioner, then such information may, after notification to the requestor, be sent to a private contractor, and such costs shall be payable by the requestor.

Added by Laws 1986, c. 315, § 15, emerg. eff. June 24, 1986.

Amended by Laws 1994, c. 294, § 1, eff. Sept. 1, 1994; Laws 1997, c. 418, § 20, eff. Nov. 1, 1997; Laws 2009, c. 432, § 4, eff. July 1, 2009.

§36-322. Violations – Penalties.

The Insurance Commissioner may, if the Commissioner finds that any person or organization has violated the provisions of any statute, rule, bulletin, or order for which the Commissioner has jurisdiction, impose a penalty of not more than Five Thousand Dollars (\$5,000.00) for each such violation. Such penalties may be in addition to any other penalty provided by law.

No penalty shall be imposed except upon a written order of the Commissioner or the appointed independent hearing examiner, stating the findings of the Commissioner or the appointed independent hearing examiner after notice and opportunity for a hearing in accordance with Article II of the Administrative Procedures Act.

Added by Laws 2024, c. 345, § 7, eff. Nov. 1, 2024.

§36-323. Commissioner enforcement power and authority.

In addition to any powers herein before expressly enumerated in this law, the Insurance Commissioner shall have full power and authority to enforce by regulations, orders, bulletins or otherwise all and singular, the provisions of this law, and the full intent thereof. In particular the Commissioner shall have the authority and power:

1. To examine all records of persons or organizations falling under the jurisdiction of the Commissioner and to require the same to furnish under oath such information as the Commissioner may deem necessary for the administration of this law. The expense of such examination shall be paid by the insurer or advisory organization examined. In lieu of such examination, the Commissioner may, in the discretion of the Commissioner, accept a report of examination made by any other insurance supervisory authority;

2. To make and enforce such reasonable bulletins, orders, rules and regulations as may be necessary in making this law effective, but such bulletins, orders, rules and regulations shall not be contrary to or inconsistent with the provisions of this law; and

3. To issue an order in accordance with Article II of the Administrative Procedures Act to all parties in interest requiring any person or organization falling under the jurisdiction of the

Commissioner to cease and desist from any unfair or unreasonable practice.

Added by Laws 2024, c. 345, § 8, eff. Nov. 1, 2024.

§36-331. Repealed by Laws 2006, c. 264, § 81, eff. July 1, 2006.

§36-332. Commissioner examinations and investigations.

A. The Insurance Commissioner may conduct such examinations and investigations of matters, within the scope of the authority of the Commissioner, as the Commissioner may deem proper to secure information useful in the lawful administration of the applicable provisions of the Oklahoma Insurance Code and other statutes for which the Commissioner has jurisdiction.

B. The Insurance Commissioner shall have the authority to employ actuaries, statisticians, accountants, attorneys, auditors, investigators or any other technicians as the Insurance Commissioner may deem necessary or beneficial to examine any filings for rate revisions made by insurers or advisory organizations and to examine such records of the insurers or advisory organizations as may be deemed appropriate in conjunction with the filing for a rate revision in order to determine that the rates or other filings are consistent with the terms, conditions, requirements and purposes of the Insurance Code, and to verify, validate and investigate the information upon which the insurer or advisory organization relies to support such filing.

1. The Commissioner shall maintain a list of technicians qualified pursuant to rules adopted by the Commissioner who are proficient in the lines of insurance being reviewed. Upon request of the Commissioner, the Commissioner shall employ the next available technician in rotation on the list, proficient in the line or lines of insurance being reviewed. The Commissioner may deviate from the list when employing technicians for loss cost filings pursuant to Section 901.5 of this title.

2. All reasonable expenses incurred in such filing review shall be paid by the insurer or advisory organization making the filing.

C. The Commissioner shall employ examiners to ensure that the rates which have been approved by or filed with the Commissioner are the rates which are being used by the insurer or by the insurers whose advisory organization has had a rate approval or rate filing.

1. Any insurer or company examined pursuant to the provisions of this section shall pay all reasonable charges incurred in such examination including the actual expense of the Commissioner and the expenses and compensation of the authorized representative of the Commissioner and the expense and compensation of assistants and examiners employed therein.

2. All expenses incurred in such examination shall be verified by affidavit and a copy shall be filed and kept in the office of the Insurance Commissioner.

Added by Laws 1957, p. 226, § 332, operative July 1, 1957. Amended by Laws 1965, c. 60, § 5, eff. July 1, 1965; Laws 1979, c. 276, § 2, emerg. eff. June 5, 1979; Laws 1980, c. 322, § 6, eff. Jan. 1, 1981; Laws 1986, c. 207, § 79, operative July 1, 1986; Laws 1987, c. 210, § 5, eff. July 1, 1987; Laws 2001, c. 363, § 4, eff. July 1, 2001; Laws 2006, c. 264, § 7, eff. July 1, 2006; Laws 2021, c. 472, § 7, emerg. eff. May 11, 2021; Laws 2024, c. 345, § 9, eff. Nov. 1, 2024.

§36-333. Repealed by Laws 2006, c. 264, § 81, eff. July 1, 2006.

§36-334.1. Training of rate analysts and assistant rate analysts - Tuition and fees.

The Insurance Commissioner is hereby authorized to arrange for the training of rate analysts and assistant rate analysts. Funds appropriated to the Insurance Commissioner may be used to pay the tuition and fees of the above personnel while receiving training related to the operations of the Property and Casualty Division. Added by Laws 1981, c. 192, § 4, emerg. eff. May 22, 1981. Amended by Laws 1982, c. 238, § 4, emerg. eff. May 4, 1982; Laws 1986, c. 207, § 81, operative July 1, 1986; Laws 2006, c. 264, § 8, eff. July 1, 2006.

§36-335. Conflicts of interest - Exceptions.

No employee of the Insurance Department shall be financially interested, directly or indirectly, in any insurer, agency or insurance transaction except as a policyholder or claimant under a policy; except, that as to such matters wherein a conflict of interest does not exist on the part of any such individual, the Insurance Commissioner may employ from time to time insurance actuaries or other technicians who are independently practicing their professions even though similarly employed by insurers and others. This section shall not be deemed to prohibit employment by the Insurance Commissioner of retired or pensioned personnel of insurers or insurance organizations. In addition, this section shall not be deemed to prohibit employees of the Insurance Department from investing in mutual funds that may own stock in insurance companies, or from having an interest in retirement or pension plans, other than self-directed plans, that may own stock in insurance companies.

Added by Laws 1957, p. 226, § 335. Amended by Laws 1980, c. 322, § 9, eff. Jan. 1, 1981; Laws 1986, c. 207, § 82, operative July 1, 1986; Laws 1997, c. 418, § 21, eff. Nov. 1, 1997.

§36-341.1. Repealed by Laws 1997, c. 418, § 125, eff. Nov. 1, 1997.

§36-344. Repealed by Laws 1997, c. 418, § 125, eff. Nov. 1, 1997.

§36-346. Repealed by Laws 2006, c. 264, § 81, eff. July 1, 2006.

§36-348.1. Fees and licenses.

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

1. Rating organizations, statistical agents and advisory organizations:

- a. Application fee for issuance of license.....\$200.00
- b. License fee.....\$500.00

2. Miscellaneous:

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

- b. Upon each transaction of filing of documents required pursuant to Section 3610 of this title and the Service Warranty Act, as contained in Sections 141.1 through 141.32 of Title 15 of the Oklahoma Statutes:

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

- (2) For an approved joint underwriting association, or rating or advisory organization:

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

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

3. For each rate, loss cost and rule filing request pursuant to the Property and Casualty Competitive Loss Cost Rating Act:

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

- b. For an approved joint underwriting association, rating or advisory organization:

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

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

B. The fees, licenses, and taxes imposed by the Commissioner upon persons, firms, associations, or corporations licensed pursuant to this section shall be payment in full with respect thereto of and in lieu of all demands for any and all state, county, district, and municipal license fees, license taxes, business privilege taxes, business privilege fees, and charges of every kind now or hereafter imposed upon all such persons, firms, associations, or corporations.

This subsection shall not affect other fees, licenses and taxes imposed by the Insurance Code.

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

Added by Laws 1957, p. 229, § 348.1, operative July 1, 1957.

Amended by Laws 1965, c. 60, § 7, eff. July 1, 1965; Laws 1980, c. 322, § 14, eff. Jan. 1, 1981; Laws 1983, c. 248, § 4, emerg. eff.

June 21, 1983; Laws 1985, c. 236, § 3, operative Sept. 1, 1985; Laws 1986, c. 207, § 86, operative July 1, 1986; Laws 1987, c. 210, § 10, eff. July 1, 1987; Laws 1991, c. 215, § 6, eff. July 1, 1991; Laws 2002, c. 307, § 4, eff. Nov. 1, 2002; Laws 2005, c. 129, § 1, eff. Nov. 1, 2005; Laws 2006, c. 264, § 9, eff. July 1, 2006; Laws 2009, c. 432, § 5, eff. July 1, 2009; Laws 2014, c. 275, § 3, eff. Nov. 1, 2014; Laws 2015, c. 298, § 3, eff. Nov. 1, 2015.

§36-349. Repealed by Laws 2001, c. 363, § 30, eff. July 1, 2001.

§36-350. Electronic format filing requirement.

Notwithstanding any other provision of law that requires a particular form and associated payment to be filed with the Insurance Department in paper form, or to be mailed or hand-delivered to the Insurance Department, the Insurance Commissioner may, by appropriate order, require that all filings of that specific type be filed or delivered in an electronic format. Electronic filings shall include payment of any transaction, filing, or other applicable fees.

Added by Laws 2014, c. 275, § 4, eff. Nov. 1, 2014. Amended by Laws 2024, c. 345, § 10, eff. Nov. 1, 2024.

§36-351. Renumbered as § 1938 of this title by Laws 1997, c. 418, § 127, eff. Nov. 1, 1997.

§36-352. Commissioner authorized to refund certain fees.

A. 1. Upon request by an applicant, the Insurance Commissioner may refund to the applicant all or any portion of any fees collected by the Commissioner pursuant to law including but not limited to any unearned fees and application fees. Such fees may be refunded, if requested, prior to any official action being taken by the Commissioner or prior to the occurrence of the action for which the application was made or in such other circumstances that the Commissioner deems proper.

2. The Commissioner may retain a portion of the fee if it is determined that administrative costs were incurred by the Insurance Department in the action.

B. The Commissioner shall promulgate permanent rules and may promulgate emergency rules to implement the provisions of this section pursuant to the Administrative Procedures Act.
Added by Laws 1997, c. 418, § 24, eff. Nov. 1, 1997.

§36-353. Repealed by Laws 1999, c. 397, § 47, emerg. eff. June 10, 1999.

§36-361. Anti-Fraud Unit - Investigations - Confidentiality of records

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. Violations of any statute or administrative rule of this state pertaining to suspected insurance fraud or pertaining to any insurance product, insurance organization, or licensee under the regulation or authority of the Commissioner may be investigated by the Anti-Fraud Unit. 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 administrative or civil action it deems necessary or advisable.

C. The Anti-Fraud Unit may employ investigators who may be 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 Unit as a result of an inquiry or investigation of any suspected insurance related crime shall be confidential and shall not be subject to the Oklahoma Open Records Act or to outside review or release by any individual. 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.
Added by Laws 1999, c. 344, § 1, emerg. eff. June 8, 1999. Amended by Laws 2002, c. 307, § 5, eff. Nov. 1, 2002; Laws 2004, c. 131, § 1; Laws 2005, c. 129, § 2, eff. Nov. 1, 2005; Laws 2009, c. 176, § 21, eff. Nov. 1, 2009; Laws 2012, c. 235, § 4, eff. July 1, 2012; Laws 2016, c. 97, § 1, eff. Nov. 1, 2016.

§36-362. Fees - Transfer to Attorney General's Insurance Fraud Unit Revolving Fund.

An annual fee of Seven Hundred Fifty Dollars (\$750.00) shall be paid to the Insurance Commissioner to be expended by the Insurance Commissioner for the purposes of investigation of suspected insurance fraud and civil or administrative action in cases involving suspected insurance fraud. The following shall pay an annual fee of Seven Hundred Fifty Dollars (\$750.00) to the Insurance Department which shall be payable quarterly in the amount of One Hundred Eighty-seven Dollars and fifty cents (\$187.50): Life, accident and health insurers; property and casualty insurers; county mutual fire insurers; mutual benefit associations; fraternal benefit societies; reciprocal insurers; motor service clubs; title insurers; nonprofit insurers; health maintenance organizations (HMOs); service warranty associations; surplus lines carriers; multiple employer welfare arrangements (MEWAs); trusts which write surety policies; prepaid dental plan organizations; and accredited reinsurers. The payments shall be due on or before the last day of the month following each calendar quarter. Beginning in the calendar year 2010, payment of the annual fee shall be made as one payment of Seven Hundred Fifty Dollars (\$750.00) which shall be paid on or before July 1. Within sixty (60) days after each calendar quarter in which monies are collected, the Commissioner shall transfer twenty-five percent (25%) of all monies collected by the Insurance Department pursuant to this section to the Attorney General's Insurance Fraud Unit Revolving Fund created in Section 19.3 of Title 74 of the Oklahoma Statutes, for use by the Attorney General in the investigation and prosecution of insurance fraud.

Added by Laws 1999, c. 344, § 2, emerg. eff. June 8, 1999. Amended by Laws 2001, c. 363, § 5, eff. July 1, 2001; Laws 2002, c. 307, § 6, eff. Nov. 1, 2002; Laws 2004, c. 131, § 2; Laws 2006, c. 264, § 10, eff. July 1, 2006; Laws 2009, c. 432, § 6, eff. July 1, 2009.

§36-363. Notification of suspected fraud - Immunity.

A. Any insurer, employee or agent of any insurer who has reason to believe that a person or entity has engaged in or is engaging in an act or practice that violates any statute or administrative rule of this state related to insurance fraud shall immediately notify the Anti-Fraud Unit of the Insurance Department and, in the case of an allegation of claimant fraud, the Workers' Compensation and Insurance Fraud Unit of the Office of the Attorney General.

B. No insurer, employee or agent of an insurer, or any other person acting in the absence of fraud, bad faith, reckless disregard for the truth, or actual malice shall be subject to civil liability for libel, slander or any other relevant tort or subject to criminal prosecution by virtue of filing of reports or furnishing other information either orally or in writing, concerning suspected,

anticipated or completed fraudulent insurance acts to the Anti-Fraud Division of the Insurance Department or the Workers' Compensation and Insurance Fraud Unit of the Office of the Attorney General pursuant to subsection A of this section or to any other agency involved in the investigation or prosecution of suspected insurance fraud.

C. No civil or criminal cause of action of any nature shall exist against the person or entity by virtue of filing of reports or furnishing other information, either orally or in writing, concerning suspected, anticipated or completed fraudulent insurance acts to the Anti-Fraud Division of the Insurance Department pursuant to subsection A of this section or to any other agency involved in the investigation or prosecution of suspected insurance fraud. The immunity provided in this subsection shall extend to the act of providing or receiving information or reports to or from:

1. Law enforcement officials, their agents and employees;

2. The National Association of Insurance Commissioners, any state department of insurance, any federal or state agency or bureau established to detect and prevent fraudulent insurance activities, as well as any other organization established for the same purpose, their agents, employees or designees; and

3. Any organization or person involved in the prevention and detection of fraudulent insurance activities or that organization or person's employees, agents, or representatives.

The immunity provided in this subsection shall not extend to any person, insurer, or agent of an insurer for communications or publications about suspected insurance fraud to any other person or entity.

Added by Laws 1999, c. 344, § 3, emerg. eff. June 8, 1999. Amended by Laws 2012, c. 175, § 1, emerg. eff. May 1, 2012; Laws 2012, c. 235, § 5, eff. July 1, 2012.

§36-364. Seizure of property used in insurance-related crimes.

A. Any tool, implement or instrumentality used or possessed in connection with any violation of an insurance-related crime or that is the fruit of an insurance-related crime, may be seized by a member of a state or local law enforcement agency upon process issued by any court of competent jurisdiction.

B. Seizure of property described in subsection A of this section may be made by a member of a state or local law enforcement agency without process if:

1. The seizure occurs in accordance with any applicable law or rule;

2. The seizure is incident to inspection under an administrative inspection warrant;

3. The seizure is incident to search made under a search warrant;

4. The seizure is incident to a lawful arrest;
5. The seizure is made pursuant to a valid consent to search;
6. The property seized has been the subject of a prior judgment in favor of the state in a criminal proceeding, or in an injunction or forfeiture proceeding under this act; or
7. There are reasonable grounds to believe that the property is directly or indirectly dangerous to health or safety.

C. When property is seized under this section, the seizing agency may:

1. Place the property under seal; or
2. Remove the property to a place selected and designated by the seizing agency.

Added by Laws 2012, c. 235, § 6, eff. July 1, 2012.

§36-365. Insurance-related crime property - Forfeiture - Replevin.

A. The following are subject to forfeiture:

1. Any tool used to commit an insurance-related crime;
2. Any implement of an insurance-related crime;
3. Any instrumentality of an insurance-related crime; and
4. Any fruit of an insurance-related crime.

B. A forfeiture of an item or other conveyance encumbered by a bona fide security interest is subject to the interest of the secured party where the secured party neither had knowledge of nor consented to the act or omission forming the ground for the forfeiture.

C. Property, described in subsection A of this section, seized and held for forfeiture shall not be subject to replevin and is subject only to the order and judgments of a court of competent jurisdiction hearing the forfeiture proceedings.

D. 1. The district attorney in the county where the seizure occurs or the Attorney General or the Insurance Department shall bring an action for forfeiture in a court of competent jurisdiction. The forfeiture action shall be brought within sixty (60) days from the date of seizure except where the attorney prosecuting the forfeiture in the sound exercise of discretion determines that no forfeiture action should be brought because of the rights of property owners, lienholders or secured creditors or because of exculpatory, exonerating or mitigating facts and circumstances.

2. The attorney prosecuting the forfeiture shall give notice of the forfeiture proceeding by mailing a copy of the complaint in the forfeiture proceeding to each person whose right, title, or interest of record in the Oklahoma Tax Commission, the Department of Public Safety, the Federal Aviation Agency, or any other department of the state or any other state or territory of the United States, or of the federal government, if the property is required to be registered in any such department.

3. Notice of the proceeding shall be given to any other person as may appear, from the facts and circumstances, to have any right, title or interest in or to the property.

4. The owner of the property or any person having or claiming right, title or interest in the property may, within sixty (60) days after the mailing of the notice, file a verified answer to the complaint and may appear at the hearing on the action for forfeiture.

5. The attorney prosecuting the forfeiture shall show at a forfeiture hearing, by a preponderance of the evidence, that the property was used in the commission of a violation of an insurance-related crime, or was the fruit of an insurance-related crime.

6. The owner of property may show by a preponderance of the evidence that the owner did not know and did not have reason to know that the property was to be used or possessed in the commission of any violation or that any of the exceptions to forfeiture are applicable.

7. Unless the attorney prosecuting the forfeiture shall make the showing required of it, the court shall order the property released to the owner. Where the attorney prosecuting the forfeiture has made such a showing, the court may order:

- a. the property to be destroyed by the agency which seized it or some other agency designated by the court,
- b. the property be delivered and retained for use by the Insurance Department, or
- c. the property be sold at public sale.

E. A copy of a forfeiture order shall be filed with the sheriff of the county in which the forfeiture occurs and with each federal or state department with which the property is required to be registered. The order, when filed, constitutes authority for the issuance to the Insurance Department of a title certificate, registration certificate or other special certificate as may be required by law considering the condition of the property.

F. Proceeds from sale at public auction, after payment of all reasonable charges and expenses incurred by the agency designated by the court to conduct the sale in storing and selling the property, shall be paid to the Insurance Department Anti-Fraud Revolving Fund.

G. Seizing agencies shall utilize their best efforts to arrange for the towing and storing of motor vehicles in the most economical manner possible. The owner of a motor vehicle or a motor vehicle part shall not be required to pay more than the minimum reasonable costs of towing and storage.

H. A seized item that is neither forfeited nor unidentifiable shall be held subject to the order of the court in which the criminal action is pending or, if a request for its release from the custody is made until the district attorney has notified the

defendant or the defendant's attorney of the request and both the prosecution and defense have been afforded a reasonable opportunity for an examination of the property to determine its true value and to produce or reproduce, by photographs or other identifying techniques, legally sufficient evidence for introduction at trial or other criminal proceedings. Upon expiration of a reasonable time for the completion of the examination which shall not exceed fourteen (14) days from the date of service upon the defense of the notice of request for return of property as provided, the property shall be released to the person making the request after satisfactory proof of the person's entitlement to the possession thereof. Upon application by either party with notice to the other, the court may order retention of the property if it determines that retention is necessary in the furtherance of justice.

I. When a seized item is forfeited, restored to its owner or disposed of as unidentifiable, the seizing agency shall retain a report of the transaction for a period of at least one (1) year from the date of the transaction.

J. When an applicant for a certificate of title or salvage certificate presents to the Oklahoma Tax Commission proof that the applicant purchased or acquired an item at a public sale conducted pursuant to this section and the fact is attested to by the seizing agency, the Oklahoma Tax Commission shall issue the appropriate certificate of title upon receipt of the statutory fee and properly executed application for a certificate of title.

Added by Laws 2012, c. 235, § 7, eff. July 1, 2012.

§36-401. Short title.

Sections 1 through 6 of this act shall be known and may be cited as the "Crimes By or Affecting Persons Engaged in the Business of Insurance Act".

Added by Laws 2008, c. 184, § 1, eff. July 1, 2008.

§36-402. Persons prohibited from engaging in business of insurance - Exception - Penalty.

A. No person who has been convicted of any criminal felony involving dishonesty or a breach of trust, or who has been convicted of an offense under Section 1033 of Title 18 of the United States Code, shall engage or participate in the business of insurance in this state or do any of the acts of an insurance business as set forth in Section 4 of this act.

B. A person described in subsection A of this section may engage in the business of insurance or participate in such business if such person has the written consent of the Insurance Commissioner.

C. A person who violates subsection A of this section or any rule promulgated pursuant thereto 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.

D. The business of insurance includes title insurers for purposes of the Crimes by or Affecting Persons Engaged in the Business of Insurance Act.

Added by Laws 2008, c. 184, § 2, eff. July 1, 2008.

§36-403. Powers of Insurance Commissioner - Injunctive relief.

A. Whenever the Insurance Commissioner has reason to believe or it appears that any person has violated subsection A of Section 2 of this act, the Insurance Commissioner may:

1. Revoke any license or registration issued or approved by the Insurance Commissioner;

2. Issue an ex parte cease and desist order under the procedures provided by Section 5 of this act;

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

4. Institute in the district court of Oklahoma County a civil suit to recover a civil penalty as provided for in Section 2 of this act; or

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

B. On application for injunctive relief and a finding that a person is violating or threatening to violate any provision of the Crimes By or Affecting Persons Engaged in the Business of Insurance Act or order of the Insurance Commissioner issued pursuant to the Crimes By or Affecting Persons Engaged in the Business of Insurance Act, the district court shall grant the injunctive relief and the injunction shall be issued without bond.

Added by Laws 2008, c. 184, § 3, eff. July 1, 2008.

§36-404. Business of insurance.

Any one of the following acts in this state affected by mail or otherwise is defined to be doing the business of insurance 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 on 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;

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. Ownership in whole or in part, directly or indirectly, of any entity involved in the business of insurance;

10. Acquiring or assisting others in the acquisition or attempted acquisition of any entity involved in the business of insurance;

11. Possessing a license, registration or permit issued or approved by the Insurance Commissioner;

12. Any other transactions of business in this state by an insurance company, producer, title insurance producer, adjuster, third-party administrator, service warranty association, title insurer or any other person that is licensed by or registered with the Insurance Commissioner; or

13. The doing of 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.

Added by Laws 2008, c. 184, § 4, eff. July 1, 2008.

§36-405. Emergency cease and desist order - Hearing - Judicial review - Attorneys fees.

A. On issuance of an emergency cease and desist order under Section 3 of this act, the Insurance Commissioner shall serve on the person affected by the order, by registered or certified mail, return receipt requested, to the person's last-known address, or by other lawful means, an order that contains a statement of the charges and requires the person immediately to cease and desist from the violation of subsection A of Section 2 of this act.

B. 1. If a person affected by an emergency cease and desist order seeks to contest that order, the person may request a hearing before the Insurance Commissioner. The person affected must request the hearing not later than the thirtieth day after the date on which the person receives the order. A request to contest an order must be in writing and directed to the Insurance Commissioner and must state the grounds for the request to set aside or modify the order.

2. On receiving the request for a hearing, the Insurance Commissioner shall serve notice of the time and place of the hearing at which the person requesting the hearing shall have the opportunity to show cause why the order should not be affirmed. The hearing is to be held not later than the tenth day after the date the Insurance Commissioner receives the request for a hearing unless the parties mutually agree to a later hearing date.

3. Pending the hearing, an emergency cease and desist order continues in full force and effect unless the order is stayed by the Insurance Commissioner.

4. The hearing on the order shall be conducted according to the procedures for contested cases under the Administrative Procedures Act.

5. At the hearing, the Insurance Commissioner shall affirm, modify or set aside in whole or in part the emergency cease and desist order.

C. A person aggrieved by a final order of the Insurance Commissioner pursuant to the Crimes By or Affecting Persons Engaged in the Business of Insurance Act may seek judicial review pursuant to Section 318 of Title 75 of the Oklahoma Statutes.

D. The Insurance Commissioner may recover reasonable attorney fees if judicial action is necessary for enforcement of the order.

E. A cease and desist order is final thirty-one (31) days after the date it is received if the person affected by the order does not request a hearing as provided by subsection B of this section.

Added by Laws 2008, c. 184, § 5, eff. July 1, 2008.

§36-406. Rules.

The Insurance Commissioner may promulgate rules necessary to carry out the provisions of the Crimes By or Affecting Persons Engaged in the Business of Insurance Act.

Added by Laws 2008, c. 184, § 6, eff. July 1, 2008.

§36-601. "Domestic" insurer defined.

A "domestic" insurer is one formed under the laws of Oklahoma. Laws 1957, p. 230, § 601.

§36-602. "Foreign" insurer defined.

A "foreign" insurer is one formed under the laws of another state or government of the United States.

Laws 1957, p. 230, § 602.

§36-603. "Alien" insurer defined.

An "alien" insurer is one formed under the laws of a country other than the United States.

Laws 1957, p. 230, § 603.

§36-604. "State," "United States" defined.

A. "State" means any state, commonwealth, territory, or district of the United States.

B. "United States" includes the states, territories, districts, and commonwealths thereof.

Laws 1957, p. 230, § 604.

§36-605. "Charter" defined.

"Charter" means articles of incorporation, of agreement, of association, or other basic constituent document of a corporation, subscribers' agreement and power of attorney of a reciprocal insurer, or underwriters' agreement and power of attorney of a Lloyd's insurer.

Laws 1957, p. 231, § 605.

§36-606. Authority to transact insurance required.

A. No person shall act as an insurer and no insurer shall transact insurance in Oklahoma except as authorized by a subsisting authority granted to it by the Insurance Commissioner, except as to such transactions as are expressly otherwise provided for in this Code.

B. No such authority shall be required for an insurer, formerly so licensed in Oklahoma and now licensed in another state as a resident insurer or who has merged with an insurer in another state, to enable it to investigate and settle losses under its policies lawfully written in Oklahoma, or to liquidate such assets and liabilities of the insurer (other than collection of new premiums) as may have resulted from its former authorized operations in Oklahoma.

C. An insurer, who has relocated in another state or has merged with an insurer in another state and is not transacting new insurance business in Oklahoma but continuing collection of premiums on and servicing of policies remaining in force as to residents of or risks located in Oklahoma, is transacting insurance in Oklahoma for the purpose of premium tax requirements only and is not required to have a certificate of authority therefor. This subsection shall not apply to insurers which have withdrawn from Oklahoma prior to the effective date of this Code.

D. As to an insurance coverage on a subject of insurance not resident, located, or expressly to be performed in Oklahoma at time of issuance, and solicited, written, and delivered outside Oklahoma at the time of issuance, no such authority shall be required of an insurer as to subsequent transactions in Oklahoma on account thereof, and the provisions of this Code shall not apply to such insurance or insurance coverage, except for the purpose of premium tax requirements.

Amended by Laws 1985, c. 328, § 5, emerg. eff. July 29, 1985.

§36-606.1. Certain foreign or alien insurers may become domestic insurers - Requirements and procedures.

A. 1. Any foreign or alien insurer which is organized under the laws of any other jurisdiction for the purpose of transacting insurance may become a domestic insurer by complying with all of the requirements of law relative to the organization and licensing of a domestic insurer of the same type and by designating its principal place of business at a location in this state, provided the Insurance Commissioner approves the insurer's application for redomestication. Such domestic insurer will be entitled to like certificates and licenses to transact business in this state and shall be subject to the authority and jurisdiction of this state.

2. The Commissioner shall approve an insurer's application to redomesticate unless he or she finds that:

- a. the insurer cannot comply with all the requirements of law relative to the organization and licensing of a domestic insurer,
- b. after redomestication, the insurer would not be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which it is presently licensed,
- c. the effect of the redomestication would be substantially to lessen competition in insurance in this state or tend to create a monopoly therein,
- d. the financial condition of the insurer is such as might jeopardize or prejudice the interest of its policyholders or the state and is not in the public interest, or
- e. the competence, experience and integrity of those persons who control the operation of the insurer are such that it would not be in the interest of the policyholders, the public or the state to permit the redomestication.

3. The insurer's application to redomesticate shall contain information acceptable to the Commissioner concerning its financial condition, its plan of operation for the succeeding three (3) years, and information concerning the competence, experience and integrity of those persons who control the operation of the insurer.

4. If the Commissioner determines that grounds exist to disapprove the application to redomesticate, a public hearing shall be held. The application for redomestication shall be deemed approved unless the Commissioner has, within thirty (30) days after the conclusion of the hearing, entered his or her order disapproving the redomestication.

B. Any domestic insurer may, upon the approval of the Insurance Commissioner, transfer its domicile to any other state in which it is admitted to transact the business of insurance, and upon such a transfer, shall cease to be a domestic insurer, and shall be admitted to this state if qualified as a foreign insurer. The Commissioner shall approve any such proposed transfer unless he or she shall determine such transfer is not in the interest of the policyholders of this state.

C. The certificate of authority, agents appointments and licenses, rates, and other items which the Insurance Commissioner allows, in his or her discretion, which are in existence at the time any insurer licensed to transact the business of insurance in this state transfers its corporate domicile to this or any other state by merger, consolidation or any other lawful method shall continue in full force and effect upon such transfer if such insurer remains duly qualified to transact the business of insurance in this state. All outstanding policies and other contracts of any transferring

insurer shall remain in full force and effect and need not be endorsed as to the new name of the company or its new location unless so ordered by the Commissioner. Every transferring insurer shall file new policy forms with the Commissioner on or before the effective date of the transfer, but may use existing policy forms with appropriate endorsements if allowed by, and under such conditions as approved by, the Commissioner. However, every such transferring insurer shall notify the Commissioner of the details of the proposed transfer, and shall file promptly, any resulting amendments to corporate documents required to be filed with the Commissioner.

D. The Insurance Commissioner may promulgate rules and regulations to carry out the purposes of this section. Added by Laws 1989, c. 320, § 1, eff. Nov. 1, 1989. Amended by Laws 2018, c. 306, § 1; Laws 2024, c. 345, § 11, eff. Nov. 1, 2024.

§36-607. General qualifications to transact insurance.

A. To qualify for and hold authority to transact insurance in Oklahoma an insurer must be otherwise in compliance with the provisions of the Oklahoma Insurance Code and with its charter powers, and must be an incorporated stock insurer, an incorporated mutual insurer, a mutual benefit association, a nonprofit hospital service and medical indemnity corporation, a farmers mutual fire insurance association, a Lloyd's association or a reciprocal insurer, of the same general type as may be formed as a domestic insurer under this Code; except, that no foreign or alien insurer shall be authorized to transact insurance in Oklahoma which does not maintain reserves as required by Article 15 of this Code applicable to the kind or kinds of insurance transacted by such insurer.

B. No certificate of authority or license to transact any kind of direct insurance business in this state shall be issued, renewed or continued in effect, to any domestic, foreign or alien insurance company or other insurance entity which is owned or financially controlled in whole or in part by another state of the United States, or by a foreign government, or by any political subdivision of either, or which is an agency of any such state, government or subdivision.

C. A domestic, foreign, or alien insurance company, or entity thereof which is owned or financially controlled in whole or in part by another state of the United States, a foreign government, or any political subdivision thereof, or which is an agency of any such state, government, or subdivision may apply only for a certificate of authority as a reinsurer. Such insurance company or entity shall establish and maintain a regional home office in this state, in a building owned or leased by the insurer, that employs Oklahoma employees as defined pursuant to Section 625.1 of this title. Insurance companies or entities obtaining a certificate of authority

under this subsection shall maintain security deposits pursuant to this Code in a bank as defined pursuant to Section 102 of Title 6 of the Oklahoma Statutes.

D. Any insurance company or other insurance entity which is owned or financially controlled in whole or in part by any federally recognized American Indian tribe or nation may apply for a certificate of authority or license to transact insurance business in this state and will not be subject to subsection B of this section.

E. Insurers under the jurisdiction of the Insurance Commissioner shall keep any contact information deemed necessary by the Commissioner on file with the Insurance Department. Contact information shall be kept current and submitted electronically in the manner and form prescribed by the Commissioner, along with any applicable fees. Any change in contact information shall be submitted within twenty (20) days of the change.

Added by Laws 1957, p. 231, § 607, operative July 1, 1957. Amended by Laws 2013, c. 82, § 1, eff. Nov. 1, 2013; Laws 2022, c. 152, § 1, eff. Nov. 1, 2022; Laws 2024, c. 345, § 12, eff. Nov. 1, 2024.

§36-607.1. Certain entities considered insurers - Audited financial reports - Actuarial opinions.

A. An entity organized pursuant to the Interlocal Cooperation Act (an "Interlocal Entity") for the purpose of transacting insurance that insures an Oklahoma educational institution shall be considered an insurer for all kinds of insurance that the entity transacts. Such an entity shall hold a certificate of authority to transact insurance in this state.

B. Any entity organized pursuant to the Interlocal Cooperation Act that insures an Oklahoma educational institution and has within a twelve-month period received premiums or contributions of any amount for any kind of insurance that the Interlocal Entity transacts shall have an annual audit by an independent certified public accountant and shall file an audited financial report by an independent certified public accountant with the Insurance Commissioner within one hundred eighty (180) days immediately following the close of the Interlocal Entity's fiscal year. The annual audited financial report shall be presented in conformity with accounting principles generally accepted in the United States of America and include:

1. The report of an independent certified public accountant in accordance with accounting principles generally accepted in the United States of America;
2. A balance sheet reporting assets, liabilities and equity;
3. A statement of operations;
4. A statement of cash flows;
5. A statement of changes in assets, liabilities and equity;

6. Footnotes to financial statements; and

7. An unqualified opinion from the certified public accountant that the audited financial report represents a fair presentation of the Interlocal Entity's financial position in conformity with accounting principles generally accepted in the United States of America.

C. Any entity subject to the provisions of subsection B of this section, except those entities which purchase full insurance coverage as determined by the Commissioner, shall file with the Insurance Commissioner an actuarial opinion prepared by a qualified actuary within one hundred eighty (180) days immediately following the close of the Interlocal Entity's fiscal year. The actuarial opinion should certify the amount and adequacy of the Interlocal Entity's reserves for loss and loss adjustment expenses, including amounts for Incurred But Not Reported (IBNR) Claims, and the adequacy of the Interlocal Entity's premiums. The actuarial opinion shall be consistent with the appropriate Actuarial Standards of Practice (ASOP) as promulgated by the Actuarial Standards Board.

As used in this section, "qualified actuary" means an individual who is a member of the American Academy of Actuaries and who has met the Qualification Standards for Actuaries Issuing Statements of Actuarial Opinions in the United States promulgated by the American Academy of Actuaries.

D. Extensions of the filing date may be granted by the Commissioner for thirty-day periods upon a showing by the Interlocal Entity and its independent certified public accountant or qualified actuary 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.

E. The Commissioner may assess a fine for failure to file the required annual audit or actuarial opinion in an amount of not more than Five Hundred Dollars (\$500.00) per day.

F. The audited financial reports and actuarial opinions required herein are subject to public inspection pursuant to the Oklahoma Open Records Act.

G. The Insurance Commissioner shall, if there is substantial reason to believe that any insurer subject to this section is insolvent, or if any such insurer's condition is such as to render the continuance of its business hazardous to the public or to holders of its policies or certificates of insurance, or it has exceeded its powers, or it has failed to comply with the law, or if such insurer gives its consent:

1. Notify the insurer and its participating members of the Commissioner's determination;

2. Require the insurer to file with the Insurance Commissioner a written plan of action to abate the Commissioner's determination within thirty (30) days of notification; and

3. If the Commissioner makes a further determination to supervise, notify the insurer that it is under supervision pursuant to this section.

H. An insurer subject to subsection G of this section shall comply with the lawful requirements of the Commissioner and, if placed under supervision, shall have ninety (90) days from the date of notice within which to comply with the requirements of the Commissioner unless the Commissioner designates a lesser or greater period of time or unless the Commissioner determines at any time during or after the ninety-day period of time that judicial or administrative proceedings should be initiated to place such insurer in conservation, rehabilitation or liquidation proceedings or other delinquency proceedings, pursuant to Sections 1801 through 1920 of this title. If such insurer does not comply with such requirements, such supervision may continue until such requirements are remedied or until the Commissioner approves or completes pursuit of additional options as provided in the Insurance Code.

I. The Commissioner may assess a fine for failure to timely file a written plan of action required under subsection G of this section in an amount of not more than Five Hundred Dollars (\$500.00) per day.

J. The Insurance Commissioner may promulgate rules to implement the provisions of this section.

Added by Laws 1994, c. 214, § 1, eff. July 1, 1994. Amended by Laws 2006, c. 83, § 1, eff. Nov. 1, 2006; Laws 2013, c. 306, § 1, emerg. eff. May 16, 2013; Laws 2014, c. 39, § 1, eff. Nov. 1, 2014; Laws 2015, c. 296, § 1, eff. Nov. 1, 2015; Laws 2016, c. 73, § 2, eff. Nov. 1, 2016; Laws 2021, c. 423, § 1, eff. Nov. 1, 2021.

§36-608. Workers' compensation insurance.

A. A casualty insurer shall not be authorized to transact workers' compensation insurance in this state without first complying with the applicable provisions of Title 85A of the Oklahoma Statutes.

B. A claims adjuster for any insurer duly authorized to transact workers' compensation insurance in Oklahoma shall be licensed pursuant to the Insurance Adjusters Licensing Act.

Added by Laws 1957, p. 231, § 608, operative July 1, 1957. Amended by Laws 2010, c. 355, § 1, eff. Nov. 1, 2010; Laws 2015, c. 298, § 4, eff. Nov. 1, 2015.

§36-608.2. Assigned risk plan for employers unable to procure coverage in the voluntary market.

A. The Insurance Commissioner shall develop and administer an assigned risk plan to provide workers' compensation insurance coverage to employers who are unable to procure coverage in the voluntary market. In addition to the requirements of subsection B of this section, the plan shall include but not be limited to qualifications for and termination of coverage.

B. To qualify for coverage under the plan, an employer shall have been declined coverage by at least two unaffiliated insurers and shall provide documentation to the Commissioner that the unaffiliated insurers are unwilling to provide coverage at any premium level that is reasonably related to the risk presented by the employer.

C. Any employer satisfying the requirements of subsection B of this section, and any other qualifications established by the Commissioner, shall be provided coverage at a premium level to be determined or approved by the Insurance Commissioner. Premiums shall be actuarially sound, consistent with industry standards for classification and rate-making methodologies and calculated to enable the plan to be self-sustaining and able to operate without subsidies from employers and insurers in the voluntary market, to the extent possible. Rates shall not be excessive, inadequate or unfairly discriminatory, pursuant to Section 902 of Title 36 of the Oklahoma Statutes.

D. The Insurance Commissioner may designate a third party including a private carrier or rating organization with substantial experience in developing and administering similar programs in other states, to develop and administer the assigned risk plan for a three-year period beginning on the effective date of this act. Following this period, the Commissioner shall contract with the same or another qualified third party to continue the administration of the assigned risk plan; provided, however, that the Commissioner shall approve the plan prior to the plan becoming operative. The plan established pursuant to this section shall require that all private carriers participate as a condition of their authority to transact business in this state.

E. Prior to the operation of the plan established pursuant to the provisions of this section, but in no event later than June 1, 2024, CompSource Mutual Insurance Company, a private, domestic mutual insurance company incorporated in this state and regulated by the Insurance Department, successor-in-interest to CompSource Oklahoma, shall serve as the residual market mechanism for those insureds who would otherwise be in the assigned risk plan. Added by Laws 2022, c. 304, § 2, eff. Nov. 1, 2022.

§36-609. Kinds of insurance an insurer may transact.

An insurer which otherwise qualifies therefor may be authorized to transact any one kind or combination of kinds of insurance as defined in Section 701 et seq. of this title, except:

1. A life insurer shall not be authorized to transact any other kind of insurance except accident and health and workers' compensation and employer liability equivalent insurance if otherwise qualified to do so on or after September 1, 1994, or if immediately prior to the effective date of this Code any life insurer lawfully held a subsisting certificate of authority granting it the right to transact in Oklahoma additional kinds of insurance other than accident and health, so long as the insurer is otherwise in compliance with this Code the Insurance Commissioner shall continue to authorize such insurer to transact the same kinds of insurance as those specified in such prior certificate of authority;
2. A reciprocal insurer shall not transact life insurance;
3. A Lloyd's insurer shall not transact life insurance;
4. A title insurer shall be a stock insurer and shall not transact any other kind of insurance; and
5. No insurer shall issue for delivery or deliver in this state any contract of insurance which imposes contingent or assessment liability upon a resident of this state.

Added by Laws 1957, p. 231, § 609. Amended by Laws 1981, c. 112, § 1; Laws 1986, c. 251, § 4, eff. Nov. 1, 1986; Laws 1995, c. 355, § 1, eff. July 1, 1995; Laws 2015, c. 298, § 5, eff. Nov. 1, 2015.

§36-610. Capital funds or minimum surplus required.

A. To qualify for authority to incorporate an insurance company or to transact any one or more kinds of insurance an insurer shall possess and maintain, after the effective date of this act, surplus in regard to policyholders, which is defined as the aggregate of the capital and surplus, in an amount not less than One Million Five Hundred Thousand Dollars (\$1,500,000.00).

B. Any domestic insurer lawfully authorized to transact the business of insurance in Oklahoma immediately prior to the effective date of this act shall not be required to increase its capital or surplus to meet increased requirements of this act, provided, however, that in no event shall such insurer reduce its capital or surplus below the figure required of such insurer on October 31, 2002.

C. Wherever the language paid-in capital, capital, capital stock or a similar term (if a stock company) or surplus, expendable surplus or a similar term (if a mutual or reciprocal insurer) is used elsewhere in this code, the term surplus in regard to policyholders may be used interchangeably when applicable.

Added by Laws 1957, p. 232, § 610, operative July 1, 1957. Amended by Laws 1961, p. 266, § 1, emerg. eff. March 29, 1961; Laws 1967, c.

231, § 1, emerg. eff. May 4, 1967; Laws 1980, c. 185, § 1, eff. Oct. 1, 1980; Laws 2002, c. 307, § 7, eff. Nov. 1, 2002.

§36-611. Repealed by Laws 2003, c. 150, § 8, eff. Nov. 1, 2003.

§36-612. Additional kinds of insurance - Requirements.

A. An insurance company which incorporates or is authorized initially to transact the business of insurance in Oklahoma after the effective date of this act may transact all kinds of insurance with no additional capital or surplus requirements.

B. An insurance company which incorporated or was initially authorized to transact the business of insurance in Oklahoma prior to the effective date of this act and which is otherwise qualified therefor may be authorized to transact combinations of kinds of insurance (other than the life and accident and health combination shown in Section 610 of this article) while possessing and maintaining thereafter additional surplus in regard to policyholders not less in amount than that determined in subsection C of this section.

C. For any lawful combination add One Hundred Thousand Dollars (\$100,000.00) for each additional kind of insurance included in the combination, to the amount required under Section 610 of this article for that one kind of insurance in the combination for which the largest amount is required under said Section 610, except:

1. Vehicle and accident and health insurance may be combined with casualty, and in any combination including casualty, without funds in addition to those required because of casualty.

2. An insurer, if otherwise qualified therefor, may be authorized to transact all kinds of insurance except life and title insurance.

3. The amount of such surplus in regard to policyholders shall not in any event be less than would be required if the insurer proposed to transact in Oklahoma all those kinds of insurance which it is transacting elsewhere.

Laws 1957, p. 233, § 612; Laws 1967, c. 231, § 2, emerg. eff. May 4, 1967; Laws 1980, c. 185, § 3, eff. Oct. 1, 1980.

§36-612.1. Kinds of insurance; requirements.

No insurer organized or authorized to write or issue noncancelable or guaranteed renewable accident and health policies in any state shall be, or continue to be, licensed to do business in this state unless the insurer possesses and maintains a surplus as regards policyholders in excess of Two Million Dollars (\$2,000,000.00). Insurers licensed in this state on or before November 1, 1984, may maintain no less than One Million Dollars (\$1,000,000.00) surplus as regards policyholders. Amended by Laws 1984, c. 149, § 3, eff. Nov. 1, 1984.

§36-612.2. Workers' compensation insurance - Required capital and surplus.

After November 1, 1987, no insurer who requests to write workers' compensation insurance in this state shall be permitted to transact the business of workers' compensation insurance in this state unless the insurer possesses and maintains a surplus as regards policyholders, as defined in Section 610 of Title 36 of the Oklahoma Statutes, in excess of Five Million Dollars (\$5,000,000.00). Should the surplus as regards policyholders fall below Five Million Dollars (\$5,000,000.00), the insurer shall not be permitted to write any additional workers' compensation insurance until the surplus meets the statutory requirements as established in this section.

Added by Laws 1987, c. 175, § 4, eff. Nov. 1, 1987.

§36-613. Deposit requirements.

A. Except as provided in subsection C of this section, any insurer that incorporates or is authorized initially to transact the business of insurance in Oklahoma after October 1, 1980, shall not be issued a certificate of authority by the Insurance Commissioner unless it has deposited in trust with the Commissioner cash or securities eligible for the investment of capital funds of domestic insurers under this Code in an amount not less than Three Hundred Thousand Dollars (\$300,000.00). The Commissioner may require a greater amount to be deposited in trust if the Insurance Commissioner finds that a greater amount is warranted for the protection of the policyholders of the insurer pursuant to rules promulgated by the Commissioner. Any amount over Three Hundred Thousand Dollars (\$300,000.00) must be documented and reasons stated by the Commissioner in writing for the excess deposit amount. The Commissioner will annually review those insurers with deposits above Three Hundred Thousand Dollars (\$300,000.00) to determine whether such additional deposits remain justified.

B. The Commissioner shall not issue a certificate of authority to any insurer that incorporated or was initially authorized to transact the business of insurance in Oklahoma prior to October 1, 1980, unless it has deposited in trust with the Commissioner cash or securities eligible for the investment of capital funds of domestic insurers under this Code in an amount not less than the surplus in regard to policyholders, or net admitted assets (if a Lloyd's association) required pursuant to this Code to be maintained for authority to transact the kinds of insurance to be transacted, except that in the case of life and/or accident and health insurers the deposit shall be in the amount of One Hundred Thousand Dollars (\$100,000.00).

C. 1. As to domestic title insurers, the deposit shall be as required by Article 50 (Title Insurers).

2. As to foreign insurers, in lieu of such deposit or part thereof in this state, the Commissioner may accept the current certificate in proper form of the public official having supervision over insurers in any other state to the effect that a like deposit or part thereof by such insurer is being maintained in public custody in such state in trust for the purpose, among other reasonable purposes, of protection of all the insurer's policyholders or of all its policyholders and creditors.

3. As to alien insurers, other than title insurers, in lieu of such deposit or part thereof in this state, the Commissioner may accept the certificate of the official having supervision over insurance of another state in the United States, given under his or her hand and seal, that the insurer maintains within the United States by way of deposits with public depositaries, or in trust institutions within the United States approved by such official, assets available for discharge of its United States insurance obligations, which assets shall be in amount not less than the outstanding liabilities of the insurer arising out of its insurance transactions in the United States, together with the largest deposit required by this Code to be made in this state by any type of domestic insurer transacting like kinds of insurance.

D. Any securities deposited by insurers shall be issued to the Commissioner and the insurer and shall not be released by any company holding such security without the signatures of the Commissioner and the authorized insurer's personnel. Failure of any company holding such security to comply with this subsection may result, after hearing by the proper licensing authority, in a fine of not more than Twenty-five Thousand Dollars (\$25,000.00) per occurrence.

Added by Laws 1957, p. 233, § 613, operative July 1, 1957. Amended by Laws 1961, p. 267, § 1, emerg. eff. June 28, 1961; Laws 1980, c. 185, § 4, eff. Oct. 1, 1980; Laws 1986, c. 251, § 5, eff. Nov. 1, 1986; Laws 2000, c. 353, § 2, eff. Nov. 1, 2000; Laws 2014, c. 275, § 5, eff. Nov. 1, 2014.

§36-613.1. Surety bond or other security arrangement required.

Any insurance company transacting the business of property and casualty insurance in this state shall not be issued a new or renewal certificate of approval unless the company has provided a corporate surety bond or approved alternative security arrangement in an amount determined by the State Insurance Commissioner to be sufficient to provide for the return of unearned premiums if a policy is canceled during the term thereof by an insurance company. The State Insurance Commissioner shall promulgate rules and

regulations to implement and carry out the provisions of this section.

Added by Laws 1986, c. 134, § 1, emerg. eff. April 17, 1986.

§36-615. Repealed by Laws 2002, c. 307, § 36, eff. Nov. 1, 2002.

§36-615.1. Application to transact insurance - Application review.

A. Unless otherwise instructed by the Insurance Commissioner, an applicant requesting to be admitted to transact insurance in this state shall follow the instructions outlined in the National Association of Insurance Commissioners (NAIC) Uniform Certificate of Authority Application (UCAA) instructions.

B. The Commissioner shall review and analyze each application with focus on the following:

1. Identification and evaluation of the business and strategic plans of the applicant, including but not limited to pro forma financial projections;

2. Assessment of the quality and expertise of the ultimate controlling person, proposed officers and directors, appointed actuary and appointed accountant, including the use of the NAIC Form A and SAD databases;

3. Adequacy of any proposed reinsurance program;

4. Adequacy of investment policy;

5. Adequacy of short-term and long-term financing arrangements, including, but not limited to:

a. initial financing of proposed operations or transaction, and

b. maintenance of adequate capital and surplus levels;

6. Biographical affidavits;

7. Related party agreements' compliance with SSAP No. 25; and

8. Any other information the Commissioner deems necessary to review.

Added by Laws 2002, c. 307, § 8, eff. Nov. 1, 2002. Amended by Laws 2011, c. 278, § 2, eff. Nov. 1, 2011.

§36-615.2. Biographical affidavit.

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

applicant and has indicated that the Biographical Affidavit has no significantly inaccurate or conflicting information and is accepted as the Business Character Report. As used in this section, "independent third party" is one that has no affiliation with the applicant and is in the business of providing background checks or investigations. The Business Character Report must be current and shall not be older than six (6) months.

Added by Laws 2004, c. 274, § 3, eff. July 1, 2004. Amended by Laws 2005, c. 129, § 3, eff. Nov. 1, 2005; Laws 2021, c. 478, § 1, emerg. eff. May 12, 2021.

§36-616. Issuance or refusal of certificate.

A. If upon completion of application the Insurance Commissioner finds that the insurer has met the requirements for and is entitled thereto under this Code, he shall issue to the insurer a proper certificate of authority; if he does not so find, the Insurance Commissioner shall issue his order refusing such certificate. The Insurance Commissioner shall not issue a certificate of authority to any domestic insurer incorporated after January 1, 1970, unless each of the shareholders of the common capital stock thereof is entitled at the shareholders meetings to one vote for each share standing in his name in the books of the corporation. The Insurance Commissioner shall act upon an application for a certificate of authority within thirty (30) days after its completion.

B. The certificate, if issued, shall specify the kind or kinds of insurance the insurer is authorized to transact in Oklahoma. At the insurer's request, the Insurance Commissioner may issue a certificate of authority limited to particular types of insurance included within a kind of insurance as defined in this code. Laws 1957, p. 234, § 616; Laws 1969, c. 289, § 1; Laws 1970, c. 109, § 1, emerg. eff. April 1, 1970.

§36-617. Renewal and amendment of certificate.

A. All certificates of authority shall, beginning November 1, 2002, be perpetual and automatically renewed as of March 1 of each year, unless the insurer fails to qualify for renewal pursuant to the requirements of the Insurance Code.

B. The Insurance Commissioner may amend a certificate of authority at any time to accord with changes in the insurer's charter or insuring powers.

Added by Laws 1957, p. 235, § 617, operative July 1, 1957. Amended by Laws 2002, c. 307, § 9, eff. Nov. 1, 2002.

§36-618. Mandatory revocation or suspension.

The Insurance Commissioner shall refuse to renew or shall revoke or suspend an insurer's certificate of authority:

1. If such action is required by any provision of this Code, or

2. If the insurer no longer meets the requirements for the authority originally granted, on account of deficiency in assets or otherwise.

Laws 1957, p. 235, § 618.

§36-619. Discretionary revocation or suspension; civil fines.

A. The Insurance Commissioner may after opportunity for a hearing refuse to renew, or may revoke or suspend an insurer's certificate of authority, in addition to other grounds in this Code, if the insurer:

1. Violates any provision of this Code other than those as to which refusal, suspension, or revocation is mandatory;

2. Knowingly fails to comply with any lawful rule or order of the Insurance Commissioner;

3. Is found by the Insurance Commissioner to be in unsound condition or in such condition as to render its further transaction of insurance in this state hazardous to its policyholders or to the people of this state;

4. Without reasonable cause compels claimants under its policies to accept less than the amount due them or to bring suit against it to secure full payment;

5. Refuses to be examined or to produce its accounts, records, and files for examination by the Insurance Commissioner when required;

6. Fails to pay any final judgment rendered against it in this state within thirty (30) days after the judgment becomes final; or

7. Is affiliated with and under the same general management or interlocking directorate or ownership as another insurer which transacts direct insurance in this state without having a certificate of authority therefor, except as permitted to a surplus line insurer pursuant to Sections 1101 through 1120 of this title.

B. In addition to or in lieu of any applicable revocation or suspension of an insurer's certificate of authority, any insurer who knowingly and willfully violates this Code may be subject to a civil penalty of not more than Five Thousand Dollars (\$5,000.00) for each occurrence.

C. In addition to or in lieu of any sanction, the Commissioner may require an insurer to restrict its insurance writings, obtain additional contributions to surplus, withdraw from the state, reinsure all or part of its business, increase capital, surplus, deposits or any other account for the security of policyholders or creditors, or provide independent actuarial review.

Added by Laws 1957, p. 235, § 619. Amended by Laws 1980, c. 182, § 1, eff. Oct. 1, 1980; Laws 1986, c. 251, § 6, eff. Nov. 1, 1986; Laws 1997, c. 418, § 25, eff. Nov. 1, 1997; Laws 2010, c. 222, § 5, eff. Nov. 1, 2010.

§36-619.1. Availability of coverage without regard to geographic location.

All insurers, as a condition of their authority to transact insurance in this state, shall make available all of the kinds of insurance coverage that they are transacting in this state to all Oklahoma residents, without regard to geographic location, but subject to the insurers' underwriting standards.

Added by Laws 1986, c. 134, § 2, emerg. eff. April 17, 1986.

§36-619.2. Workers' Compensation Fraud Unit of Office of Attorney General - Notification of certain violations.

Any insurer which has reason to believe that a person has engaged in or is engaging in an act or practice that violates any workers' compensation fraud statute or administrative rule of this state shall immediately notify the Workers' Compensation Fraud Unit of the Office of the Attorney General.

Added by Laws 1993, c. 349, § 30, eff. Sept. 1, 1993.

§36-619.3. Motor vehicle liability insurer compliance.

All insurers, as a condition of writing motor vehicle liability policies in this state, shall comply with the requirements of Section 7-600.2 of Title 47 of the Oklahoma Statutes.

Added by Laws 2009, c. 340, § 1, emerg. eff. May 27, 2009.

§36-620. Name of insurer.

A. No insurer shall be authorized to transact insurance in Oklahoma which has or uses a name so similar to that of any insurer already so authorized as to cause uncertainty or confusion; except, that in case of conflict of names between two insurers the Insurance Commissioner may permit or require the newly-authorized insurer to use in Oklahoma such supplementation or modification of its name as may reasonably be necessary to avoid such conflict.

B. No insurer shall be authorized to transact insurance in Oklahoma which has or uses a name which tends to deceive or mislead as to the type of organization of the insurer.

Laws 1957, p. 235, § 620.

§36-621. Service of legal process on foreign or alien insurers.

A. Each authorized foreign or alien insurer shall appoint the Insurance Commissioner as its agent to receive service of legal process, other than a subpoena, issued against it in this state upon any cause of action arising from its transaction of business in this state. The appointment shall be irrevocable, shall bind any successor and shall remain in effect as long as there is in force in this state any contract made by the insurer or obligations arising therefrom.

B. Service of such process against a foreign or alien insurer shall be made only by service of process upon the Insurance Commissioner. Service of process against a domestic insurer may be made upon the insurer in the manner provided by laws applying to business entities generally, or upon the insurer's attorney-in-fact if a reciprocal insurer or a Lloyds association.

C. Each such insurer at time of application for a certificate of authority shall file with the Insurance Commissioner designation of the name and address of the person to whom process against it served upon the Insurance Commissioner is to be forwarded. The insurer may change such designation by a new filing.

Added by Laws 1957, p. 235, § 621. Amended by Laws 1997, c. 418, § 26, eff. Nov. 1, 1997; Laws 1997, c. 418, § 26, eff. Nov. 1, 1997.

§36-622. Manner of service of process.

A. Triplicate copies of legal process against an insurer for whom the Insurance Commissioner is agent shall be served upon the Commissioner at the principal offices of the Insurance Department. When legal process against an insurer for whom the Insurance Commissioner is agent is issued, it shall be served in triplicate by any manner now provided by law or in lieu thereof by mailing triplicate copies of such legal process in the United States mails with postage prepaid to the Insurance Commissioner with return receipt requested, in which event service shall be sufficient upon showing of proof of mailing to the Commissioner with the return receipt attached. At the time of service the plaintiff shall pay to the Insurance Commissioner Twenty Dollars (\$20.00), taxable as costs in the action. Upon receiving service, the Insurance Commissioner shall promptly forward a copy thereof by mail with return receipt requested to the person last so designated by the insurer to receive the same.

B. Process served upon the Insurance Commissioner and copy thereof forwarded as provided in this section shall constitute service upon the insurer.

Added by Laws 1957, p. 236, § 622, operative July 1, 1957. Amended by Laws 1983, c. 68, § 6, eff. Nov. 1, 1983; Laws 1984, c. 215, § 3, operative June 30, 1984; Laws 1986, c. 251, § 7, emerg. eff. June 13, 1986; Laws 1997, c. 418, § 27, eff. Nov. 1, 1997; Laws 2009, c. 432, § 7, eff. July 1, 2009.

§36-623. Repealed by Laws 1997, c. 418, § 125, eff. Nov. 1, 1997.

§36-624. Report of premiums, fees and taxes - Payment - Penalties.

A. Every insurance company, copartnership, insurance association, interinsurance exchange, person, insurer, nonprofit hospital service and medical indemnity corporation, or health maintenance organization doing business in this state in the

execution or exchange of contracts of insurance, indemnity or health maintenance services, or as an insurance company of any nature or character whatsoever, hereinafter referred to in this article as an insurance company or company, shall annually, on or before the first day of March, report under oath of the president or secretary or other chief officer of such company to the Insurance Commissioner the total amount of direct written premiums, membership, application, policy and/or registration fees charged during the preceding calendar year, or since the last return of such direct written premiums, membership, application, policy and/or registration fees was made by such company, from insurance of every kind upon persons or on the lives of persons resident in this state, or upon real and personal property located within this state, and/or upon any other risks insured within this state, provided, that with respect to the tax payable annually, considerations received for annuity contracts and payments received by a health maintenance organization from the Secretary of Health and Human Services pursuant to a contract issued under the provisions of 42 U.S.C., Section 1395mm(g) shall no longer be deemed to be premiums for insurance and shall no longer be subject to the tax imposed by this section. Every such company shall, at the same time, pay to the Insurance Commissioner:

1. An annual license fee as prescribed by Section 321 of this title; and
2. An annual tax on all of the direct written premiums after all returned premiums are deducted, and on all membership, application, policy and/or registration fees, installment and/or finance fees or charges collected thereby, for the privileges of having written, continued and/or serviced insurance on lives, property and/or other risks in this state and of having made and serviced investments therein during the then expiring license year except premiums or fees paid by any county, city, town or school district funds or by their duly constituted authorities performing a public service organized pursuant to Sections 1001 through 1008 of Title 74 of the Oklahoma Statutes, or Sections 176 through 180.4 of Title 60 of the Oklahoma Statutes. Provided, no deduction shall be made from premiums for dividends paid to policyholders. Except as set forth in this paragraph, the rate of taxation for all entities subject to the tax shall be two and twenty-five one-hundredths percent (2.25%). If any insurance company or other entity liable for the taxes levied pursuant to the provisions of this section fails to remit such taxes in a timely manner, it shall remain liable therefor together with interest thereon at an annual rate equal to the average United States Treasury Bill rate of the preceding calendar year as certified by the State Treasurer on the first regular business day in January of each year, plus four percentage points.

- a. The rate of taxation for all life insurance policies insuring the life of an employee or director for the benefit of the employer or a trust sponsored by the employer, which is purchased by the employer or trust sponsored by the employer for the benefit of its employees, shall be computed for each policy at the rate of:
 - (1) two and twenty-five one-hundredths percent (2.25%) of policy year premium up to One Hundred Thousand Dollars (\$100,000.00), and
 - (2) one-tenth of one percent (1/10 of 1%) of policy year premium exceeding One Hundred Thousand Dollars (\$100,000.00).
- b. Premiums on which taxes are paid under division (2) of subparagraph a of this paragraph are not subject to Section 628 of this title. The Commissioner shall promulgate rules regarding the sale of life insurance policies subject to division (2) of subparagraph a of this paragraph.
- c. Proceeds from the premium tax collected under this paragraph from contracted entities under the Ensuring Access to Medicaid Act shall be deposited in the Medicaid Health Improvement Revolving Fund created in Section 23 of this act. The provisions of this subparagraph shall not be construed to affect or modify the apportionments provided in Section 312.1 of this title.

B. For all insurance companies or other entities taxed pursuant to this section, the annual license fee and tax and all required membership, application, policy, registration, and agent appointment fees shall be in lieu of all other state taxes or fees, except those taxes and fees provided for in the Insurance Code, and the taxes and fees of any subdivision or municipality of the state, except ad valorem taxes and the tax required to be paid pursuant to Section 50001 of Title 68 of the Oklahoma Statutes. Provided, such license fee, tax and membership, application, policy, registration, and appointment fees shall be in lieu of any and all ad valorem taxes levied on intangible personal property. Any company, except health maintenance organizations, failing to make such returns and payments promptly and correctly shall forfeit and pay to the Insurance Commissioner, in addition to the amount of the taxes and fees and interest, the sum of Five Hundred Dollars (\$500.00) or an amount equal to one percent (1%) of the unpaid amount, whichever is greater; and the company so failing or neglecting for sixty (60) days shall thereafter be debarred from transacting any business of insurance in this state until the taxes, fees and penalties are fully paid, and the Insurance Commissioner shall revoke the license

or certificate of authority granted to the agent or agents of that company to transact business in this state. Provided, that when any such insurance company, copartnership, insurance association, interinsurance exchange, person, insurer, or nonprofit hospital service and indemnity corporation, applies for the first time for a license to do business in Oklahoma, it shall, at the time of making such application, pay a license fee as prescribed by Section 1425 of this title, and, on or before the first day of March, following, pay the premium tax, membership, application, policy, registration, and agent appointment fees, as hereinbefore provided. Such license fee, tax and membership, application, policy, registration, and appointment fees shall be in lieu of all other state taxes or fees, except those taxes and fees provided for in the Insurance Code, and the taxes and fees of any subdivision or municipality of the state, except ad valorem taxes and the tax required to be paid pursuant to Section 50001 of Title 68 of the Oklahoma Statutes.

C. Any health maintenance organization failing to file premium tax returns and payments promptly and correctly shall forfeit and pay to the Insurance Commissioner, in addition to the amount of the taxes, the sum of Five Hundred Dollars (\$500.00) or an amount equal to one percent (1%) of the unpaid amount, whichever is greater. Any health maintenance organization failing or neglecting to pay the tax and penalty shall be debarred from operating in this state and the Insurance Commissioner shall revoke the license of the health maintenance organization, until such taxes and penalties are fully paid.

Added by Laws 1957, p. 236, § 624. Amended by Laws 1965, c. 60, § 10, eff. July 1, 1965; Laws 1965, c. 194, § 1; Laws 1979, c. 39, § 1, eff. July 1, 1979; Laws 1982, c. 138, § 1, emerg. eff. April 9, 1982; Laws 1985, c. 179, § 1, emerg. eff. June 21, 1985; Laws 1986, c. 251, § 8, eff. Nov. 1, 1986; Laws 1987, c. 175, § 5, eff. Nov. 1, 1987; Laws 1988, c. 83, § 5, emerg. eff. March 25, 1988; Laws 1989, c. 227, § 1; Laws 1989, c. 373, § 17, operative July 1, 1989; Laws 1990, c. 227, § 1, emerg. eff. May 18, 1990; Laws 1997, c. 418, § 28, eff. Nov. 1, 1997; Laws 2001, c. 363, § 6, eff. July 1, 2001; Laws 2003, c. 197, § 55, eff. Nov. 1, 2003; Laws 2010, S.J.R. No. 61, § 20; Laws 2016, c. 286, § 1; Laws 2022, c. 395, § 22, eff. July 1, 2022.

§36-624.1. Tax credit for taxes paid by domestic insurer in foreign state.

If, by the laws of any state other than this state, or by the action of any public official of another state, any insurer or company, as defined in Section 624 of this Code, organized or domiciled in this state, shall be required to pay taxes for the privilege of doing business in such other state, and such amounts are imposed or assessed so that the taxes which are or would be

imposed against Oklahoma domestic insurance companies are greater than those taxes required of insurers organized or domiciled in such other states, to the extent such amounts are legally due to such other states, an insurer or company organized or domiciled in this state may claim a credit against the tax payable pursuant to this article for any calendar year prior to 1989 of a sum not to exceed one hundred percent (100%) of such amount. Provided, for the tax attributed to premiums collected prior to July 1, 1988, the credit shall not be greater than the tax payable for such premiums; for the tax attributed to premiums collected on or after July 1, 1988 through December 31, 1988, the credit authorized by this section and the investment credit authorized by Section 625 of this title shall not reduce the tax payable for such premiums to less than one percent (1%).

Beginning with the taxes payable for calendar year 1989, the premium tax levied by Section 624 of this title shall not be reduced by the credit provided for in this section. Added by Laws 1985, c. 328, § 6, emerg. eff. July 29, 1985. Amended by Laws 1988, c. 83, § 6, emerg. eff. March 25, 1988.

§36-624.2. Refund of erroneously paid premium tax - Filing - Demand for hearing.

A. Any taxpayer who has paid to the State of Oklahoma, through error of fact, or computation, or misinterpretation of law, any premium tax collected by the Oklahoma Insurance Commissioner may, as hereinafter provided, be refunded the amount of such tax so erroneously paid, without interest.

B. Any taxpayer who has so paid any such premium tax may, within three (3) years from the date of payment thereof, file with the Insurance Commissioner a verified claim for refund of such tax so erroneously paid. The Insurance Commissioner may accept an amended premium report or return as a verified claim for refund if the amended report or return establishes a liability less than the original report or return previously filed.

C. Said claim so filed with the Insurance Commissioner, except for an amended report or return, shall specify the name of the taxpayer, certificate of authority or license number of the taxpayer, the time when and period for which said premium tax was paid, the nature and kind of premium tax so paid, the amount of the premium tax which said taxpayer claimed was erroneously paid, the grounds upon which a refund is sought, and such other information or data relative to such payment as may be necessary to an adjustment thereof by the Insurance Commissioner. It shall be the duty of the Insurance Commissioner to determine what amount of refund, if any, is due as soon as practicable, but no later than ninety (90) days after such claim has been filed, and advise the taxpayer about the

correctness of the taxpayer's claim, and the claim for refund shall be approved or denied by written notice to the taxpayer.

D. If the claim for refund is denied, the taxpayer may file a demand for hearing with the Insurance Commissioner. The demand for hearing must be filed on or before the thirtieth day after the date the notice of denial was mailed. If the taxpayer fails to file a demand for hearing, the claim for refund shall be barred.

E. Upon the taxpayer's timely filing of a demand for hearing, the Insurance Commissioner shall set a date for hearing upon the claim for refund which date shall not be later than sixty (60) days from the date the demand for hearing was mailed. The taxpayer shall be notified of the time and place of the hearing. The hearing may be held after the sixty-day period provided by this subsection upon agreement of the taxpayer.

Added by Laws 2003, c. 124, § 1, eff. Nov. 1, 2003.

§36-624.3. Refund of adverse economically targeted and home office credit deductions.

A. As used in this section:

1. "Economically targeted credits" means any credit against the insurance premium tax other than the home office credits;

2. "Home office credits" means the credits against insurance premium tax authorized pursuant to Section 625.1 of this title;

3. "Insurance premium tax" means those levies imposed pursuant to Sections 624 and 628 of this title; and

4. "Insurance premium tax liabilities" means the total liability of any insurance company created by the insurance premium tax.

B. Any taxpayer adversely affected by a requirement of the Oklahoma Insurance Department for deducting home office credits after the deduction of economically targeted credits in computation of the taxpayer's insurance premium tax liabilities for the period January 2003, through December 2006, shall be granted a refund, pursuant to the provisions of Section 624.2 of this title, for the difference between the insurance premium tax liability as it would have been computed had the home office credit been deducted prior to economically targeted credits and the insurance premium tax liability as it was actually computed for such periods.

C. The provisions of this section shall be deemed sufficient grounds for the granting of a refund claim pursuant to subsection C of Section 624.2 of this title.

D. No refund otherwise payable pursuant to the provisions of this section shall be paid to a claimant prior to July 1, 2007.

E. Refunds paid on or after July 1, 2007, pursuant to the provisions of this section shall only be paid from those insurance premium taxes and fees that would be apportioned to the General Revenue Fund of the State Treasury. No refund otherwise payable

pursuant to the provisions of this section shall be paid from insurance premium taxes or fees that would be apportioned to the Oklahoma Firefighters Pension and Retirement Fund, the Oklahoma Police Pension and Retirement System or the Law Enforcement Retirement Fund.

F. Any and all premium tax credits to be utilized or recovered in a subsequent year are fully admitted as an asset to the insurer owning or generating said credits.

Added by Laws 2005, c. 381, § 3, eff. July 1, 2006. Amended by Laws 2006, 2nd Ex. Sess., c. 44, § 1, eff. July 1, 2007.

§36-625. Credit against tax by investment in Oklahoma securities.

A. If the annual statement of any insurance company or other entity taxed pursuant to the provisions of Section 624 of this title covering the period of time from January 1, 1988 through June 30, 1988, shows it to have investments at the close of said period of time in Oklahoma securities, as hereinafter defined, of as much as two percent (2%) but less than twelve percent (12%) of its admitted assets, it will be entitled to a credit on the premium tax levied on premiums collected during said period of time by paragraph 2 of Section 624 of this article so as to reduce the same to a tax of two and three-fourths percent (2 3/4%); if said investments are as much as twelve percent (12%) but less than fourteen percent (14%) of said assets its annual premium tax shall be reduced to a tax of two and one-half percent (2 1/2%); if said investments are as much as fourteen percent (14%) but less than sixteen percent (16%) of said assets its annual premium tax shall be reduced to a tax of two and one-fourth percent (2 1/4%); if said investments are as much as sixteen percent (16%) but less than eighteen percent (18%) of said assets its annual premium tax shall be reduced to a tax of two percent (2%); if said investments are as much as eighteen percent (18%) but less than twenty percent (20%) of said assets its annual premium tax shall be reduced to a tax of one and three-fourths percent (1 3/4%); if said investments are as much as twenty percent (20%) but less than twenty-two percent (22%) of said assets its annual premium tax shall be reduced to a tax of one and one-half percent (1 1/2%); if said investments are as much as twenty-two percent (22%) but less than twenty-four percent (24%) of said assets its annual premium tax shall be reduced to a tax of one and one-fourth percent (1 1/4%); if said investments are as much as twenty-four percent (24%) but less than twenty-six percent (26%) of said assets its annual premium tax shall be reduced to a tax of one percent (1%); if said investments are as much as twenty-six percent (26%) percent but less than twenty-eight percent (28%) of said assets its annual premium tax shall be reduced to a tax of three-fourths of one percent (3/4 of 1%); if said investments are as much as twenty-eight percent (28%) but less than thirty percent (30%) of

said assets its annual premium tax shall be reduced to a tax of one-half of one percent ($1/2$ of 1%); if said investments are as much as thirty percent (30%) of said assets its annual premium tax shall be reduced to no percent (0%).

B. If the annual statement of any insurance company or other entity taxed pursuant to the provisions of Section 624 of this title covering calendar year 1988 shows it to have investments in Oklahoma securities, as hereinafter defined, for the period of time beginning July 1, 1988 through December 31, 1988, of as much as two percent (2%) but less than twelve percent (12%) of its admitted assets, it will be entitled to a credit on the premium tax levied by paragraph 2 of Section 624 of this article so as to reduce the same to a tax of two and three-fourths percent ($2\ 3/4\%$); if said investments are as much as twelve percent (12%) but less than fourteen percent (14%) of said assets its annual premium tax shall be reduced to a tax of two and one-half percent ($2\ 1/2\%$); if said investments are as much as fourteen percent (14%) but less than sixteen percent (16%) of said assets its annual premium tax shall be reduced to a tax of two and one-fourth percent ($2\ 1/4\%$); if said investments are as much as sixteen percent (16%) but less than eighteen percent (18%) of said assets its annual premium tax shall be reduced to a tax of two percent (2%); if said investments are as much as eighteen percent (18%) but less than twenty percent (20%) of said assets its annual premium tax shall be reduced to a tax of one and three-fourths percent ($1\ 3/4\%$); if said investments are as much as twenty percent (20%) but less than twenty-two percent (22%) of said assets its annual premium tax shall be reduced to a tax of one and one-half percent ($1\ 1/2\%$); if said investments are as much as twenty-two percent (22%) but less than twenty-four percent (24%) of said assets its annual premium tax shall be reduced to a tax of one and one-fourth percent ($1\ 1/4\%$); if said investments are as much as twenty-four percent (24%) of said assets its annual premium tax shall be reduced to a tax of one percent (1%). The credits authorized by this subsection and the credits authorized by Section 624.1 of this title shall not reduce the premium tax rate for premiums collected on or after July 1, 1988 through December 31, 1988, of an insurance company or other entity subject to said tax to less than one percent (1%).

C. Beginning with the taxes payable for calendar year 1989, the premium tax levied by Section 624 of this title shall not be reduced by the credits for investment of assets provided for in this section.

D. Oklahoma securities as used in this section shall mean real estate in this state, bonds of the State of Oklahoma, bonds or interest-bearing warrants of any county, city, town, school district or municipality or subdivision of the State of Oklahoma, notes or bonds secured by mortgages or other liens on real estate located in

the State of Oklahoma, cash deposits in regularly established national or state banks, Federal Savings and Loan Associations, Federal Savings Banks, or any institution insured by either the Federal Deposit Insurance Corporation or Federal Savings and Loan Insurance Corporation, in this state on the basis of the average monthly deposits throughout the calendar year, policy loans secured by the legal reserve on policies insuring residents of the State of Oklahoma, and any other Oklahoma property or securities in which by the laws of the State of Oklahoma such insurance companies may invest their funds.

Provided, that if any insurance company, copartnership, association, interinsurance exchange, person, insurer, nonprofit hospital service and medical indemnity corporation, or health maintenance organization secures such a credit prior to such a holding, it shall, within ninety (90) days after the mailing thereto by the Insurance Commissioner of a registered notice of said holding and the amount of said credit, pay said amount to the Insurance Commissioner, and if it fails to do so it shall be the duty of the Attorney General to institute proceedings in the name of the State of Oklahoma on the relation of the Insurance Commissioner in a court of competent jurisdiction to collect said amount.

Amended by Laws 1985, c. 179, § 2, emerg. eff. June 21, 1985; Laws 1988, c. 83, § 7, emerg. eff. March 25, 1988.

§36-625.1. Premium tax credit.

A. A foreign or alien insurer which is subject to the tax imposed by Section 624 of this title shall be entitled to a credit against said tax actually paid to and placed in the General Revenue Fund of the state, not including any of said tax monies placed in pension funds and not including any of said tax monies placed in escrow, if, during the year for which the tax is being assessed, the insurer or its affiliate maintained a regional home office in this state in a building owned or leased by the insurer. To receive a credit against the tax imposed for the year in which the regional home office was established, said office must have been maintained continuously from on or before August 1 of that year through the last day of the calendar year. For succeeding years, an insurer or its affiliate shall have maintained the regional home office continuously from the first day of the calendar year for which the tax is imposed through the last day of that calendar year. The Home Office Credit shall be calculated as follows:

1. Until June 30, 2010, the credit shall be equal to the following percentages of the amount due after the credits authorized by Sections 624.1 and 625 of this title have been deducted:

- a. fifteen percent (15%), if there are more than two hundred full-time, year-round Oklahoma employees, but

less than three hundred full-time, year-round Oklahoma employees,

- b. twenty-five percent (25%), if there are more than three hundred full-time, year-round Oklahoma employees, but less than four hundred full-time, year-round Oklahoma employees,
- c. thirty-five percent (35%), if there are more than four hundred full-time, year-round Oklahoma employees, but less than five hundred full-time, year-round Oklahoma employees, or
- d. fifty percent (50%), if there are five hundred or more full-time, year-round Oklahoma employees; and

2. Beginning July 1, 2010, in the calculation of the credit, the amount to be apportioned to the Oklahoma Firefighters Pension and Retirement Fund, the Oklahoma Police Pension and Retirement System and the Law Enforcement Retirement Fund shall be applied prior to the calculation of the credit. The amount of the credit shall be derived from amounts remaining after the apportionment to the Oklahoma Firefighters Pension and Retirement Fund, the Oklahoma Police Pension and Retirement System and the Law Enforcement Retirement Fund. The credit shall be calculated by first applying a "Home Office Credit Allotment Rate" of forty-seven percent (47%) to the gross premium tax owed by the insurer and then determining the allowable credit by applying the following percentages of the amount due after the credits authorized by Sections 624.1 and 625 of this title have been deducted:

- a. fifteen percent (15%), if there are more than two hundred full-time, year-round Oklahoma employees, but less than three hundred full-time, year-round Oklahoma employees,
- b. twenty-five percent (25%), if there are more than three hundred full-time, year-round Oklahoma employees, but less than four hundred full-time, year-round Oklahoma employees,
- c. thirty-five percent (35%), if there are more than four hundred full-time, year-round Oklahoma employees, but less than five hundred full-time, year-round Oklahoma employees, or
- d. fifty percent (50%), if there are five hundred or more full-time, year-round Oklahoma employees.

B. A domestic insurer with four hundred or more full-time, year-round Oklahoma employees which is subject to the tax imposed by Section 624 of this title shall be entitled to a credit against said tax actually paid to and placed in the General Revenue Fund of the state, not including any of said tax monies placed in pension funds and not including any of said tax monies placed in escrow, if, during the year previous to the year for which the tax is being

assessed, the insurer or its affiliate maintained a regional home office in this state in a building owned or leased by the insurer and during the year for which the tax is being assessed, the insurer establishes its home office in this state in a building owned or leased by the insurer. To receive a credit against the tax imposed for the year in which the home office was established, said office must have been maintained continuously from on or before August 1 of that year through the last day of the calendar year. For succeeding years, an insurer shall have maintained the home office continuously from the first day of the calendar year for which the tax is imposed through the last day of that calendar year. Insurers who take action before August 1, 2000, to establish their home office in this state shall be entitled to a credit against the tax imposed on or after January 1, 2001, which shall be in addition to the credit the insurer is entitled to for that year. The Home Office Credit shall be calculated as follows:

1. Until June 30, 2010, the credit shall be equal to the following percentages of the amount due after the credits authorized by Sections 624.1 and 625 of this title have been deducted:

- a. thirty-five percent (35%), if there are more than four hundred full-time, year-round Oklahoma employees, but less than five hundred full-time, year-round Oklahoma employees, or
- b. fifty percent (50%), if there are five hundred or more full-time, year-round Oklahoma employees; and

2. Beginning July 1, 2010, in the calculation of the credit, the amount to be apportioned to the Oklahoma Firefighters Pension and Retirement Fund, the Oklahoma Police Pension and Retirement System and the Law Enforcement Retirement Fund shall be applied prior to the calculation of the credit. The amount of the credit shall be derived from amounts remaining after the apportionment to the Oklahoma Firefighters Pension and Retirement Fund, the Oklahoma Police Pension and Retirement System and the Law Enforcement Retirement Fund. The credit shall be calculated by first applying a "Home Office Credit Allotment Rate" of forty-seven percent (47%) to the gross premium tax owed by the insurer and then determining the allowable credit by applying the following percentages of the amount due after the credits authorized by Sections 624.1 and 625 of this title have been deducted:

- a. thirty-five percent (35%), if there are more than four hundred full-time, year-round Oklahoma employees, but less than five hundred full-time, year-round Oklahoma employees, or
- b. fifty percent (50%), if there are five hundred or more full-time, year-round Oklahoma employees.

C. A domestic insurer which is subject to the tax imposed by Section 624 of this title shall be entitled to a credit against said

tax actually paid to and placed in the General Revenue Fund of the state, not including any of said tax monies placed in pension funds and not including any of said tax monies placed in escrow, if, during the year for which the tax is being assessed, the insurer maintained a regional home office in at least five or more counties in this state in buildings owned or leased by the insurer. To receive a credit against the tax imposed for the year in which the regional home offices were established, said offices must have been maintained continuously from on or before August 1 of that year through the last day of the calendar year. For succeeding years, an insurer shall have maintained the regional home offices continuously from the first day of the calendar year for which the tax is imposed through the last day of that calendar year. The Home Office Credit shall be calculated as follows:

1. Until June 30, 2010, the credit shall be equal to the percentage of the amount due after the credits authorized by Sections 624.1 and 625 of this title have been deducted as established in subsection A of this section; and

2. Beginning July 1, 2010, in the calculation of the credit, the amount to be apportioned to the Oklahoma Firefighters Pension and Retirement Fund, the Oklahoma Police Pension and Retirement System and the Law Enforcement Retirement Fund shall be applied prior to the calculation of the credit. The amount of the credit shall be derived from amounts remaining after the apportionment to the Oklahoma Firefighters Pension and Retirement Fund, the Oklahoma Police Pension and Retirement System and the Law Enforcement Retirement Fund. The credit shall be calculated by first applying a "Home Office Credit Allotment Rate" of forty-seven percent (47%) to the gross premium tax owed by the insurer and then determining the allowable credit by applying the percentage of the amount due after the credits authorized by Sections 624.1 and 625 of this title have been deducted as established in subsection A of this section.

D. Proof that an insurer qualifies for the credit authorized by this section shall be on forms prescribed by the Insurance Commissioner and shall be submitted to the Commissioner annually with the report which is filed pursuant to Section 624 of the Insurance Code.

E. The credit provided for in subsections A, B and C of this section shall be based on the total number of Oklahoma employees in the regional or home office when a group of insurers which are under common management and control maintain a regional home office or home office in this state in a building owned or leased by the group of insurers. The credit provided for in subsections A, B and C of this section may be allocated among the insurance company and the insurance company affiliates at the discretion of the insurance company on a per-insurance-company basis.

F. As used in this section:

1. "Regional home office" means an office transacting insurance, as defined in Section 105 of this title, and performing insurance company operations, which is defined as one or more or any combination of the following functions and services performed in connection with the development, sale, and administration of products giving rise to receipts subject to a premium tax on domestic and foreign insurance companies, or domestic or foreign health care insurance corporations: actuarial, medical, legal, investments, accounting, auditing, underwriting, policy issuance, information, policyholder services, premium collection, claims, advertising and publications, public relations, human resources, marketing, sales office staff, training of sales and service personnel, and clerical, managerial, and other support for any such functions or services;

2. "Common management and control" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of an insurer, whether through the ownership of voting securities, by contract, or otherwise, unless the power is executed by a person acting in an official capacity, performing duties imposed and exercising authority granted because of the person's position as an officer or employee of the insurer. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing twenty-five percent (25%) or more of the voting securities of the insurer;

3. "Oklahoma employees" means persons who are employed in Oklahoma after January 1, 2000, and who are common law employees of an insurance company or its affiliate. Oklahoma employees do not include independent contractors or any persons to the extent that the compensation of that person is based on commissions;

4. "Insurance company" means any entity subject to a premium tax on domestic and foreign insurance companies, or domestic or foreign health care insurance corporations, including the attorney-in-fact authorized by and acting for the subscribers of a reciprocal insurer or inter-insurance exchange under powers of attorney. A reciprocal and its attorney-in-fact shall be a single entity; and

5. "Home office" means the executive offices of an insurance company which is domiciled in this state.

G. Each insurer or insurance group requesting a credit under this section shall certify by affidavit, approved as to form by the Commissioner, that the insurer has met all of the qualifications required by this section and is authorized to a credit against the premium tax which actually shall be paid to, and placed in the General Revenue Fund of the state, exclusive of any amounts of the tax which shall be credited to pension funds pursuant to law and exclusive of any amounts which shall be placed into escrow. The Commissioner may do an examination for the sole purpose of

certifying that all requirements of this section are being met by the insurer requesting to obtain any credits against premium tax.

H. For the fiscal year beginning July 1, 2006, and for each fiscal year thereafter, and notwithstanding any other provisions of Title 36 of the Oklahoma Statutes or any other provision of law governing the order in which the credit authorized by this section is to be deducted from the liability of the company claiming such credit to the contrary, the credit authorized by this section shall be deducted from the insurance premium tax liability of the company claiming such credit prior to the deduction of any other credits that may be claimed against such liability.

Added by Laws 1987, c. 137, § 1, eff. Nov. 1, 1987. Amended by Laws 2000, c. 346, § 1, eff. Jan. 1, 2001; Laws 2005, c. 381, § 2, eff. July 1, 2006; Laws 2008, c. 344, § 1, eff. Nov. 1, 2008.

§36-625.2. Premium tax credit - Applicable insurers.

A. The tax credits set forth in Section 1 of this act shall apply to insurers who take action after November 1, 1987, to:

1. Establish new regional home offices; or
2. Expand existing regional home offices, and hire new employees.

B. An insurer in either category of the requirements of paragraph A of this section must also meet the hiring minimum requirements for the applicable tax credit bracket in Section 1 of this act.

Added by Laws 1987, c. 137, § 2, eff. Nov. 1, 1987.

§36-625.3. Insurance companies - Home office - Tax credit.

An insurance company that has operated a regional home office in this state that has qualified for the tax credit provided for in Section 625.1 of Title 36 of the Oklahoma Statutes and that redomiciles and moves its home office to this state shall continue to receive such tax credit under the terms for which it was originally allowed.

Added by Laws 2000, c. 315, § 10, eff. July 1, 2000.

§36-625.4. Credit against premium tax.

A. One hundred percent (100%) of any assessment paid by an insurer under the Oklahoma Property and Casualty Insurance Guaranty Association Act shall be allowed to that insurer as a credit against its premium tax levied under Section 624 of Title 36 of the Oklahoma Statutes. The tax credit referred to in this section shall be allowed at a rate of ten percent (10%) per year for ten (10) successive years following the date of assessment and, at the option of the insurer, may be taken over an additional number of years. The balance of any tax credit not claimed in a particular year may

be reflected in the books and records of the insurer as an admitted asset of the insurer for all purposes.

B. Available credit against premium tax allowed under subsection A of this section may be transferred or assigned among or between insurers if:

1. A merger, acquisition, or total assumption of reinsurance among or between the insurers occurs; or

2. The Insurance Commissioner by order approves the transfer or assignment.

Added by Laws 2002, c. 307, § 11, eff. Nov. 1, 2002.

§36-626. Collection proceedings.

If any entity such as is referred to in this article fails to pay the annual premium tax levied by Section 624 of this Code, it shall be the duty of the Attorney General to institute proceedings in the name of the State of Oklahoma on the relation of the Insurance Commissioner in a court of competent jurisdiction to collect said amount.

Amended by Laws 1985, c. 179, § 3, emerg. eff. June 21, 1985.

§36-627. Repealed by Laws 2005, c. 129, § 26, eff. Nov. 1, 2005.

§36-628. Retaliation.

When by or pursuant to the laws of any other state or foreign country any premium or income or other taxes, or any fees, fines, penalties, licenses, deposit requirements or other material obligations, prohibitions or restrictions are imposed upon Oklahoma insurers doing business, or that might seek to do business in such other state or country, which in the aggregate are in excess of such taxes, fees, fines, penalties, licenses, deposit requirements or other obligations, prohibitions or restrictions directly imposed upon similar insurers of such other state or foreign country under the statutes of this state, so long as such laws continue in force or are so applied, the same obligations, prohibitions and restrictions of whatever kind shall be imposed upon similar insurers of such other state or foreign country doing business in Oklahoma. All insurance companies of other nations shall be held to the same obligations and prohibitions that are imposed by the state where they have elected to make their deposit and establish their principal agency in the United States. Any tax, license or other obligation imposed by any city, county or other political subdivision of a state or foreign country on Oklahoma insurers or their agents shall be deemed to be imposed by such state or foreign country within the meaning of this section. The provisions of this section shall not apply to ad valorem taxes on real or personal property or to personal income taxes.

Added by Laws 1957, p. 239, § 628, operative July 1, 1957. Amended by Laws 1990, c. 258, § 80, operative July 1, 1990; Laws 2001, c. 363, § 7, eff. July 1, 2001; Laws 2010, c. 222, § 6, eff. Nov. 1, 2010; Laws 2011, c. 278, § 3; Laws 2011, c. 360, § 3.

§36-629. Estimate and prepayment of premium tax - Crediting.

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

B. All sums prepaid by an insurance company shall be allowed as credits against its annual return for premium tax payable on or before the first day of March. If sums prepaid exceed the insurance company's annual premium tax payable on or before the first day of March, the excess shall be refunded or shall be allowed as credits against subsequent prepayments of the tax as the insurance company shall elect on the annual return for premium tax filed for the year by the insurance company with respect to which such excess prepayments were made. Provided, in the case of an insurance company which has made prepayments of its premium tax in excess of its annual premium tax payable, the part of the excess prepayments as has not been credited against subsequent prepayments of the tax shall be refunded to the insurance company upon application within one hundred eighty (180) days after application is made.

Added by Laws 1971, c. 191, § 1, emerg. eff. June 4, 1971. Amended by Laws 1972, c. 59, § 1, emerg. eff. March 25, 1972; Laws 1982, c. 164, § 1, operative July 1, 1982; Laws 1988, c. 83, § 8, emerg. eff. March 25, 1988; Laws 1997, c. 418, § 29, eff. Nov. 1, 1997; Laws 2004, c. 274, § 4, eff. July 1, 2004; Laws 2005, c. 129, § 4, eff. Nov. 1, 2005.

§36-630. Failure to make payments timely - Penalties.

Failure to make such payments timely shall subject the insurance company to a penalty of ten percent (10%) of the tax due and said tax and penalty shall be further subject to interest at the rate of six percent (6%) per annum, from the date said payment should have been paid, until the tax, penalty and interest are paid.

Added by Laws 1971, c. 191, § 2, emerg. eff. June 4, 1971. Amended by Laws 2004, c. 274, § 5, eff. July 1, 2004.

§36-631. Deposit of premium tax - Payments to Medicaid Contingency Revolving Fund - Transfer of funds received from tax protest litigation.

A. Said premium tax as collected shall be deposited by the thirtieth day of the month of receipt to the credit of the General Revenue Fund subject only to the allocations thereof as otherwise provided by law.

B. That portion of premium tax assessed on the premiums of Medicaid recipients collected from the University of Oklahoma Managed Care Plan sponsored by the University of Oklahoma Health Sciences Center and from qualified health plans that contract with the Oklahoma Health Care Authority to provide managed care to participants in the State Medicaid program, as provided in Section 624 of this title, shall be paid by the thirtieth day of the month of receipt to the credit of the Medicaid Contingency Revolving Fund, created in Section 1010.8 of Title 56 of the Oklahoma Statutes. Added by Laws 1971, c. 191, § 3, emerg. eff. June 4, 1971. Amended by Laws 1987, c. 203, § 107, operative July 1, 1987; Laws 1988, c. 127, § 2, emerg. eff. April 12, 1988; Laws 1988, c. 204, § 1, operative July 1, 1988; Laws 1995, c. 331, § 1, eff. Nov. 1, 1995; Laws 1996, c. 302, § 1, eff. July 1, 1996.

§36-632. Certain entities subject to jurisdiction of Insurance Commissioner and Oklahoma Insurance Code - Exemptions.

A. Unless otherwise provided for by law or exempted by the provisions of this section, any person or other entity which provides coverage in this state for medical, surgical, chiropractic, physical therapy, speech pathology, audiology, professional mental health, dental, hospital, or ophthalmologic expenses, whether coverage is by direct payment, reimbursement, or other means, shall be presumed to be subject to the jurisdiction of the Insurance Commissioner unless the person or other entity shows that while providing coverage the person or entity is subject to the jurisdiction of another agency of this or another state, any subdivision of this state, or the federal government, or provides a plan of self-insurance or other employee welfare benefit program for an individual employer or labor union maintained pursuant to a collective bargaining agreement or other arrangement which provides for health care services solely for its employees or members and their dependents.

B. A person or entity may show that it is subject to the jurisdiction of another agency of this or another state, any subdivision of this state, or the federal government by providing to the Insurance Commissioner the certificate, license, or other document issued by the other governmental agency which permits or qualifies the person or entity to provide those services.

C. Any person or entity which is unable to show that it is subject to the jurisdiction of another agency of this or another state, any subdivision of this state, or the federal government, or provides an employee welfare benefit program for an individual employer or labor union as provided for in subsection A of this section, shall submit to an examination by the Insurance Commissioner to determine the organization and solvency of the person or entity, and to determine whether or not the person or entity is in compliance with applicable provisions of the Oklahoma Insurance Code, Section 101 et seq. of this title.

D. Any person or entity unable to show that it is subject to the jurisdiction of another agency of this or another state, any subdivision of this state, or the federal government, or provides an employee welfare benefit program for an individual employer or labor union as provided for in subsection A of this section, shall be subject to all appropriate provisions of the Oklahoma Insurance Code regarding the conduct of its business.

1. Any agent, broker, administrator, or other person or company which advertises, solicits, negotiates, procures, sells, renews, continues, or administers coverage in this state which is provided by any person or entity specified in subsection C of this section for expenses specified in subsection A of this section shall advise any purchaser, prospective purchaser, and covered person of the lack of insurance or other coverage, if the coverage for expenses specified in subsection A of this section is not fully insured or otherwise fully covered by a company authorized to do such business in this state; and

2. Any administrator who advertises or administers coverage in this state which is provided by any person or entity specified in subsection C of this section for expenses specified in subsection A of this section shall advise any agent, broker, or other person or company which advertises, solicits, negotiates, sells, procures, renews, or continues said coverage of the elements of the coverage including the amount of stop-loss insurance in effect.

E. 1. Those entities which are not licensed insurers in this state, other than a hospital service and medical indemnity corporation as authorized in Section 2601 et seq. of this title, shall place the following statement in conspicuous bold-face type on the front page of their policy or certificate: "State insurance insolvency guaranty funds are not available for your use in the event of insolvency or liquidation of this company"; and

2. Those entities which are not licensed insurers, or not subject to the jurisdiction of the Insurance Commissioner or any other state agency, shall place the following statement in conspicuous bold-face type on the front page of their policy, plan or certificate: "This policy, plan or certificate and this entity

are not subject to the jurisdiction of the Oklahoma State Insurance Commissioner".

Added by Laws 1984, c. 42, § 1, eff. Nov. 1, 1984. Amended by Laws 1987, c. 172, § 1, eff. Nov. 1, 1987; Laws 1997, c. 418, § 30, eff. Nov. 1, 1997.

§36-632.1. Home service contracts and home warranties not insurance.

Home service contracts and home warranties, as defined in Section 6752 of Title 36 of the Oklahoma Statutes, are not insurance in this state or otherwise regulated under the Insurance Code.

Added by Laws 2021, c. 137, § 3, eff. Nov. 1, 2021.

§36-633. MEWA defined - Information relating to administrative services contracts.

A. As used in this act, the term "Multiple Employer Welfare Arrangement" or "MEWA" means that term 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 meets either or both of the following criteria:

1. One or more of the employer members of the MEWA is either domiciled in this state or has its principal place of business or principal administrative office in this state; or

2. The MEWA solicits an employer that is domiciled in this state or that has its principal place of business or principal administrative office in this state.

B. Each insurer licensed to do business in this state, including any corporation organized under the provisions of Article 26 of Title 36 of the Oklahoma Statutes, that administers a MEWA shall provide the Insurance Commissioner with such information regarding the insurer's administrative services contract or contracts with such MEWA or MEWAs that the Commissioner may reasonably require.

C. A MEWA shall be administered only by a licensed insurer or a licensed third party administrator.

Added by Laws 1992, c. 374, § 1, eff. Jan. 1, 1993.

§36-634. Valid license required - Exempt entities.

A. It is unlawful to operate, maintain or establish a MEWA unless the MEWA has a valid license issued by the Insurance Commissioner. Any MEWA operating in this state without a valid license is an unauthorized insurer.

B. This act shall not apply to:

1. A MEWA that offers or provides benefits that are fully insured by an authorized insurer;

2. A MEWA that is exempt from state insurance regulation in accordance with the Employee Retirement Income Security Act of 1974 (ERISA) (Public Law 93-406);

3. Any plan that has no more than two employer members which share substantial common support other than income generated by their respective similar business classification;

4. A plan that has no more than two employer members, which together have a combined net worth of more than Five Million Dollars (\$5,000,000.00) and each of such member employers participated in the continuous sponsorship and maintenance of such MEWA for the benefit of their employees for a period of more than ten (10) years next preceding the effective date of this act; or

5. A nonprofit professional trade association pursuant to Section 501(c)(3) of the Internal Revenue Code, 26 U.S.C., Section 501(c)(3), which has maintained either a self-funded plan or a fully insured plan of coverage for the payment of expenses to or for members of the association for a period of ten (10) or more consecutive years and, if self-funded, which coverage is provided to at least five hundred covered participants.

C. Any entity which claims to be exempt from state regulation pursuant to subsection B of this section shall provide to the Commissioner strict proof establishing such exemption.

Added by Laws 1992, c. 374, § 2, eff. Jan. 1, 1993. Amended by Laws 2004, c. 416, § 1, emerg. eff. June 4, 2004; Laws 2019, c. 425, § 1, eff. Nov. 1, 2019.

§36-635. License eligibility requirements - Filing of contracts.

A. To meet the requirements for issuance of a license and to maintain a MEWA, a MEWA must be nonprofit and either:

1. a. established by a trade association, industry association or professional association of employers or professionals that has a constitution or bylaws and that has been organized and maintained in good faith for a continuous period of five (5) years for purposes other than that of obtaining or providing insurance, or
- b. established by an association that has a current M-1 form filed with and accepted by the United States Department of Labor showing Oklahoma as the state of operation and:
 - (1) is formed in accordance with the applicable provisions of 29 CFR 2510, or
 - (2) was previously established or is newly formed in accordance with federal regulatory guidance effective prior to August 20, 2018, or
- c. operated pursuant to a trust agreement by a board of trustees that has complete fiscal control over the

MEWA and that is responsible for all operations of the MEWA. Except as provided in this paragraph, the trustees must:

- (1) be owners, shareholders, partners, officers, directors, or employees of one or more employers in the MEWA. With the Commissioner's approval, a person who is not such an owner, shareholder, partner, officer, director, or employee may serve as a trustee if that person possesses the expertise required for such service. A trustee may not be an owner, shareholder, partner, officer or employee of the administrator or service company of the MEWA,
 - (2) have the authority to approve applications of association members for participation in the MEWA, and
 - (3) have the authority to contract with an authorized administrator or service company to administer the operations of the MEWA,
- d. neither offered nor advertised to the public generally,
 - e. operated in accordance with sound actuarial principles, and
 - f. offered only after Two Hundred Thousand Dollars (\$200,000.00) of cash or federally guaranteed obligations of less than five-year maturity that have a fixed or recoverable principal amount or such other investments as the Commissioner may authorize by rule is titled in such a manner that it may not be traded, sold or otherwise expended without the consent of the Commissioner; provided, the funds shall be taken into account in determining whether the MEWA is actuarially sound, and evidence of the investment shall be filed with the Commissioner; or
2. a. operated pursuant to a trust agreement for a trust which has its situs in this state, is operated pursuant to a trust agreement by a board of trustees that has complete fiscal control over the MEWA, is responsible for all operations of the MEWA, and which has as one of its trustees a financial institution which is independent of the entity which established the MEWA. Except as provided in this paragraph, the board of trustees must have owners, shareholders, partners, officers, directors or employees of one or more employers in the MEWA. With the Commissioner's approval, a person who is not such an owner, shareholder, partner, officer, director or employee

may serve as a trustee if that person possesses the expertise required for such service. A trustee shall not be an owner, shareholder, partner, officer, director or employee of the administrator or service company of the MEWA,

- b. operated and administered in a manner that causes all assets of the MEWA to be held in trust until paid either:
 - (1) for the benefit of individuals who receive medical, dental or similar benefits from the MEWA, or
 - (2) for the expenses of the MEWA, such as the fees of the trustee, licensed agents, administrator, service company, and all expenses of complying with the provisions of this act,
- c. offered only to employers for the benefit of their employees,
- d. operated in accordance with sound actuarial principles, and
- e. offered only after Two Hundred Thousand Dollars (\$200,000.00) of cash or federally guaranteed obligations of less than five-year maturity that have a fixed or recoverable principal amount or such other investments as the Commissioner may authorize by rule is titled in such a manner that it may not be traded, sold or otherwise expended without the consent of the Insurance Commissioner; provided, the funds shall be taken into account in determining whether the MEWA is actuarially sound, and evidence of the investment shall be filed with the Commissioner.

B. 1. The MEWA shall issue to each covered employee a policy, contract, certificate, summary plan description, or other evidence of the benefits and coverages provided. The policy, contract, certificate, summary plan description, or other evidence of the benefits, coverages provided, premium rates to be charged and any contracts between the MEWA and any administrator or service company, including any changes to those documents, must be filed with the Oklahoma Insurance Department. The evidence of benefits and coverages provided shall contain, in boldface type on the face page of the policy and the certificate, the following statement: "THE BENEFITS AND COVERAGES DESCRIBED HEREIN ARE PROVIDED THROUGH A TRUST FUND ESTABLISHED BY A GROUP OF EMPLOYERS (name of MEWA). THE TRUST FUND IS NOT SUBJECT TO ANY INSURANCE GUARANTY ASSOCIATION. OTHER RELATED FINANCIAL INFORMATION IS AVAILABLE FROM YOUR EMPLOYER OR FROM THE (name of MEWA). EXCESS INSURANCE IS PROVIDED BY A LICENSED INSURANCE COMPANY TO COVER CERTAIN CLAIMS WHICH EXCEED CERTAIN

AMOUNTS. THIS IS THE ONLY SOURCE OF FUNDING FOR THESE BENEFITS AND COVERAGES."

2. If applicable, the same documents shall contain in boldface type on the face page of the policy and the certificate: "THE BENEFITS AND COVERAGE DESCRIBED HEREIN ARE FUNDED BY CONTRIBUTIONS FROM EMPLOYERS, EMPLOYEES, AND OTHER INDIVIDUALS ELIGIBLE FOR COVERAGE."

3. Any statement required by this subsection is not required on identification cards issued to covered employees or other insureds.

C. The Commissioner shall not grant or continue a license to any MEWA if the Commissioner reasonably deems that:

1. Any trust, manager or administrator is incompetent, untrustworthy, or so lacking in insurance expertise as to make the operations of the MEWA hazardous to the potential and existing insureds;

2. Any trustee, manager or administrator has been found guilty of or has pled guilty or no contest to a felony, a crime involving moral turpitude, or a crime punishable by imprisonment of one (1) year or more under the law of any state or country, whether or not a judgment or conviction has been entered; or

3. Any trustee, manager or administrator has had any type of insurance license justifiably revoked in this or any other state.

D. To qualify for and retain a license, a MEWA shall file all contracts with administrators or service companies with the Commissioner, and report any changes in such contracts to the Commissioner in advance of their implementation. The Commissioner shall have the authority to cause any contract with an administrator or service company to be renegotiated if the Commissioner reasonably determines that the charges under any such contract are excessively high in light of the services being delivered under the contract.

E. An initial filing fee of One Thousand Dollars (\$1,000.00) is required for licensure. Each subsequent year the MEWA is in operation, an annual fee of Two Hundred Fifty Dollars (\$250.00) shall be required.

F. Failure to maintain compliance with the eligibility requirements established by this section is a ground for denial, suspension or revocation of the license of a MEWA.

Added by Laws 1992, c. 374, § 3, eff. Jan. 1, 1993. Amended by Laws 2002, c. 129, § 1, eff. Nov. 1, 2002; Laws 2014, c. 275, § 6, eff. Nov. 1, 2014; Laws 2019, c. 425, § 2, eff. Nov. 1, 2019.

§36-636. Use of words or descriptions causing beneficiaries to believe MEWA is insurance company.

No licensed MEWA shall use in its name, contracts, literature, advertising in any medium, or any other printed matter any words or descriptions which would cause beneficiaries or potential beneficiaries to believe it is an insurance company.

Added by Laws 1992, c. 374, § 4, eff. Jan. 1, 1993.

§36-637. Application for license.

Each MEWA shall file with the Insurance Commissioner an application for a license on a form prescribed by the Commissioner and signed under oath by officers of the association or the administrator of the MEWA. The application shall include or have attached the following:

1. A copy of any articles of incorporation, constitution and bylaws of any association;

2. A list of the names, addresses and official capacities with the MEWA of the individuals who will be responsible for the management and conduct of the affairs of the MEWA, including all trustees, officers and directors. Such individuals shall fully disclose the extent and nature of any contracts or arrangements between them and the MEWA, including possible conflicts of interest;

3. A copy of the articles of incorporation, bylaws or trust agreement that governs the operation of the MEWA;

4. A copy of the policy, contract, certificate, summary plan description or other evidence of the benefits and coverages provided to covered employees, including a table of the rates charged or proposed to be charged for each form of such contract. A qualified actuary shall certify that:

a. the rates are neither inadequate, nor excessive, nor unfairly discriminatory,

b. the rates are appropriate for the classes of risks for which that have been computed, and

c. an adequate description of the rating methodology has been filed with the Commissioner and such methodology follows consistent and equitable actuarial principles.

For purposes of this section and Section 639 of this title, a "qualified actuary" is an actuary who is a Fellow of the Society of Actuaries (FSA), a member of the American Academy of Actuaries, or an Enrolled Actuary under the Employee Retirement Income Security Act of 1974, 29 U.S.C., Section 1001 et seq., and has experience in establishing rates for a self-insured trust and health services being provided;

5. Any administrator retained by the MEWA must be a licensed third-party administrator. The MEWA must provide proof of a fidelity bond which shall protect against acts of fraud or dishonesty in servicing the MEWA, covering each person responsible for servicing the MEWA, in an amount equal to the greater of ten percent (10%) of the contributions received by the MEWA or ten percent (10%) of the benefits paid, during the preceding calendar year, with a minimum amount requirement of Twenty Thousand Dollars (\$20,000.00) and a maximum amount requirement of Five Hundred Thousand Dollars (\$500,000.00);

6. A copy of the MEWA's stop-loss agreement. The stop-loss insurance agreement must be issued by an insurer authorized to do business in this state and must provide both specific and aggregate coverage with an aggregate retention of no more than one hundred twenty-five percent (125%) of the expected claims for the next plan year and a specific retention amount as annually indicated in the actuarial opinion;

7. In the initial application, a feasibility study, made by a qualified actuary with an opinion acceptable to the Commissioner, that addresses market potential, market penetration, market competition, operating expenses, gross revenues, net income, total assets and liabilities, cash flow and other items as the Commissioner requires. The study shall be for the greater of three (3) years or until the MEWA has been projected to be profitable for twelve (12) consecutive months. The study must show that the MEWA would not, at any month end of the projection period, have less than ninety percent (90%) of the reserves as required by a qualified actuary;

8. A copy of an audited financial statement of the MEWA prepared by an independent licensed certified public accountant;

9. A copy of every contract between the MEWA and any administrator or service company; and

10. Such additional information as the Commissioner may reasonably require.

Added by Laws 1992, c. 374, § 5, eff. Jan. 1, 1993. Amended by Laws 2002, c. 129, § 2, eff. Nov. 1, 2002; Laws 2019, c. 425, § 3, eff. Nov. 1, 2019.

§36-638. Compliance with provisions of Title 36 relating to examinations, deposits and solvency regulation.

Every Multiple Employer Welfare Arrangement shall comply with Articles 15 through 19 and Sections 309.1 through 309.7, 311.1 and 619 of this title which pertain to examinations, deposits and solvency regulation.

Added by Laws 1992, c. 374, § 6, eff. Jan. 1, 1993. Amended by Laws 2021, c. 478, § 2, emerg. eff. May 12, 2021.

§36-639. Annual financial report - Actuarial certification - Quarterly financial statements - Penalties.

A. Every MEWA shall, within ninety (90) days after the end of each fiscal year of the MEWA, or within any such extension of time that the Insurance Commissioner for good cause grants, file a report with the Commissioner, on forms acceptable to the Commissioner and verified by the oath of a member of the board of trustees or chief executive officer of any governing association and by the administrator of the MEWA, showing its financial condition on the last day of the preceding fiscal year. The report shall contain an

audited financial statement of the MEWA prepared in accordance with generally accepted accounting principles, including its balance sheet and a statement of the operations for the preceding fiscal year certified by an independent accounting firm or independent individual holding a permit to practice certified public accounting in this state. The report shall also include an analysis of the adequacy of reserves and contributions or premiums charged, based on a review of past and projected claims and expenses.

B. In conjunction with the annual report required in subsection A of this section, the MEWA shall submit an actuarial certification prepared by a qualified independent actuary that indicates:

1. The MEWA is actuarially sound, with the certification considering the rates, benefits, and expenses of, and any other funds available for the payment of obligations of the MEWA;

2. The rates being charged and to be charged for contracts are actuarially adequate to the end of the period for which rates have been guaranteed;

3. The recommended amount of cash reserves the MEWA should maintain, which shall not be less than the greater of twenty percent (20%) of the total contributions in the preceding plan year or twenty percent (20%) of the total estimated contributions for the current plan year. The cash reserves shall be calculated with proper actuarial regard for known claims, paid and outstanding, a history of incurred but not reported claims, claims handling expenses, unearned premiums, a trend factor, and a margin for error. Cash reserves required by this section shall be maintained in cash or federally guaranteed obligations of less than five-year maturity that have a fixed or recoverable principal amount or such other investments as the Commissioner may authorize by rule;

4. Whether amounts reserved to cover the cost of health care benefits are:

- a. calculated in accordance with the loss reserving standards that would be applicable to a private insurance company writing the same coverage,
- b. computed in accordance with accepted loss reserving standards, including a reserve for Incurred But Not Reported Claims (IBNR), and
- c. fairly stated in accordance with sound loss reserving standards;

5. The recommended level of specific and aggregate stop-loss insurance that the MEWA should maintain and whether the MEWA is funding at the aggregate retention plus all other costs of the MEWA; and

6. Such other information relating to the performance of the MEWA that is reasonably required by the Commissioner.

C. The MEWA shall send an annual report to all of the employers, describing the financial condition of the MEWA as of the

end of the last fiscal year. The report must be sent at the same time as the filing of the annual statement of the MEWA.

D. The Commissioner may require a MEWA to file quarterly, within forty-five (45) days after the end of each of the remaining fiscal quarters, a financial statement on a form prescribed by the Commissioner, verified by the oath of a member of the board of trustees and an administrator of the MEWA, showing its financial condition on the last day of the preceding quarter and the statement of a qualified actuary setting forth the actuary's opinion relating to the level of cash reserves in accordance with paragraphs 3 and 4 of subsection B of this section.

E. Any MEWA that fails to file a report as required by this section is subject to Section 311 of this title; and, after notice and opportunity for hearing, the Commissioner may suspend the MEWA's authority to enroll new insureds or to do business in this state while the failure continues.

Added by Laws 1992, c. 374, § 7, eff. Jan. 1, 1993. Amended by Laws 2002, c. 129, § 3, eff. Nov. 1, 2002; Laws 2019, c. 425, § 4, eff. Nov. 1, 2019.

§36-640. Denial, suspension or revocation of license - Corrective action plans - Rescission or modification of suspension order.

A. The Insurance Commissioner shall deny, suspend or revoke a MEWA's license if, after notice and opportunity for a hearing, the Commissioner finds that the MEWA:

1. Is insolvent;
2. Is using such methods and practices in the conduct of its business as to render its further transaction of business in this state hazardous or injurious to its participating employees, covered employees and dependents, or to the public;
3. Has failed to pay any final judgment rendered against it in a court of competent jurisdiction within sixty (60) days after the judgment became final;
4. Is or has been in violation of any material provisions of this act;
5. Is no longer actuarially sound; or
6. Is charging rates that are excessive, inadequate or unfairly discriminatory.

B. The Commissioner may deny, suspend or revoke the license of any MEWA if, after notice and opportunity for a hearing, the Commissioner determines that the MEWA:

1. Has violated any lawful order or rule of the Commissioner or any applicable provisions of this act;
2. Has refused to produce its accounts, records or files for examination under Sections 309.1 through 310A.3 of this title or through any of its officers has refused to give information with

respect to its affairs or to perform any other legal obligation as to an examination;

3. Utilized persons to solicit enrollments through an unlicensed agent; or

4. Has violated any provision of the Unfair Claims Settlement Practices Act, Section 1250.1 et seq. of this title.

C. Whenever the financial condition of the MEWA is such that, if not modified or corrected, its continued operation would result in impairment or insolvency, in addition to any provisions in this act, the Commissioner may order the MEWA to file with the Commissioner and implement a corrective action plan designed to correct such impairment or insolvency.

If the MEWA fails to submit a plan within the time specified by the Commissioner or submits a plan that is insufficient, the Commissioner may order the MEWA to implement corrective actions as necessary to correct the MEWA's financial condition.

D. The Commissioner shall, in any order suspending the authority of a MEWA to enroll new insureds, specify the period during which the suspension is to be in effect and the conditions, if any, that must be met prior to reinstatement of its authority to enroll new insureds. The order of suspension is subject to rescission or modification by further order of the Commissioner before the expiration of the suspension period. Reinstatement shall not be made unless requested in writing by the MEWA; however, the Commissioner shall not grant reinstatement if it is found that the circumstances for which suspension occurred still exist.

Added by Laws 1992, c. 374, § 8, eff. Jan. 1, 1993. Amended by Laws 2019, c. 425, § 5, eff. Nov. 1, 2019.

§36-641. Promulgation of rules relating to multiple employer welfare arrangements.

The Insurance Commissioner may promulgate rules to implement the provisions of Sections 633 through 640 of Title 36 of the Oklahoma Statutes relating to multiple employer welfare arrangements.

Added by Laws 2002, c. 129, § 4, eff. Nov. 1, 2002.

§36-650. Competition with Nine-One-One system prohibited.

Insurers, nonprofit health service plans, and health maintenance organizations shall not establish or promote an emergency medical response, triage, or transportation system in competition with or in substitution of the Nine-One-One system. Insurers, nonprofit health service plans, and health maintenance organizations shall not use false or misleading language to discourage or prohibit access to the Nine-One-One system.

Added by Laws 2000, c. 353, § 3, eff. Nov. 1, 2000.

§36-660.1. Definitions.

As used in this act, unless the context otherwise requires:

1. "Board" means the board of directors of a converting mutual insurer;
2. "Conversion" means a process by which a domestic mutual insurer is converted to a domestic stock insurer as part of a reorganization;
3. "Converted stock insurer" means a domestic stock insurer into which a domestic mutual insurer is converted as part of a reorganization;
4. "Converting mutual insurer" means a domestic mutual insurer that is converting to a domestic stock insurer as part of a reorganization;
5. "Effective date" means, with respect to a plan, the date on which the plan or a part of the plan becomes effective as set forth in an order of the Oklahoma Insurance Commissioner;
6. "Eligible member" means a member of the converting mutual insurer whose insurance policy is in force as of the date on which the board adopts the plan of reorganization or on some other date that the plan specifies as the record date and that the Insurance Commissioner approves;
7. "Intermediate stock holding company" means a corporation that satisfies all of the following:
 - a. the corporation was incorporated under Title 18 of the Oklahoma Statutes,
 - b. a mutual holding company holds directly or indirectly at least a majority of the corporation's voting stock, and
 - c. the corporation holds directly or indirectly at least a majority of the voting stock of a converted stock insurer;
8. "Member" means:
 - a. with respect to a domestic mutual insurer, a member as described in Section 2115 of Title 36 of the Oklahoma Statutes, or
 - b. with respect to a mutual holding company, any holder of one or more policies of insurance, other than a policy of reinsurance, issued by the converted stock insurer resulting from a reorganization involving the organization of a mutual holding company and, if permitted under the articles of incorporation or bylaws of the mutual holding company, may include any holder of one or more policies of insurance, other than a policy of reinsurance, issued by any other insurer that is a direct or indirect subsidiary or affiliate of the mutual holding company;
9. "Membership interest" means:

- a. with respect to a converting mutual insurer, a member of a domestic mutual insurer shall have the same character of rights and relationship as a stockholder has toward a domestic stock insurer, with respect to the management, records, and affairs of the insurer, or
- b. with respect to a mutual holding company on and after the effective date of the plan, any right that a member of the mutual holding company may hold by virtue of membership in the mutual holding company arising under the articles of incorporation and bylaws of the mutual holding company, including the right to vote for the board;

10. "Mutual holding company" means a corporation that is formed and existing under the laws of this state and pursuant to the reorganization of a mutual insurance company;

11. "Plan" means a plan of reorganization;

12. "Reorganization" means a process by which a domestic mutual insurer is converted to a domestic stock insurer and a mutual holding company is organized; and

13. "Voting stock" means:

- a. stock of any class or any percentage ownership interest having voting power for the election of directors, trustees or management, and
- b. includes stock having voting power only by reason of the happening of a contingency.

Added by Laws 2024, c. 194, § 1, eff. Nov. 1, 2024.

§36-660.2. Effect of conversion.

A. On the effective date of a plan of reorganization, all of the following occur:

1. The converting mutual insurer becomes a converted stock insurer. The amended or restated articles of incorporation and bylaws of the converting mutual insurer shall be filed with the Oklahoma Insurance Commissioner as part of the plan and shall become effective on the effective date of the conversion. The Insurance Commissioner shall amend the certificate of authority of the converting mutual insurer on the effective date of the conversion;

2. All membership interests and rights in surplus of the converting mutual insurer are extinguished and the members of the converting mutual insurer become members of the mutual holding company in accordance with this act and the articles of incorporation and bylaws of the mutual holding company;

3. Any owner of one or more policies of insurance, other than a policy of reinsurance, issued by the converted stock insurer after the effective date of the conversion and, if permitted under the articles of incorporation or bylaws of the mutual holding company,

any holder of one or more policies of insurance, other than a policy of reinsurance, issued by any other insurer that is a direct or indirect subsidiary or affiliate of the mutual holding company after the effective date of the reorganization becomes a member of the mutual holding company;

4. The mutual holding company or, if created, an intermediate stock holding company acquires and shall retain all shares of the voting stock of the converted stock insurer;

5. The mutual holding company acquires and shall retain all shares of the voting stock of any intermediate stock holding company; and

6. A converted stock insurer continues the corporate existence of the converting mutual insurer. Except as provided in the plan, the conversion does not annul, modify or change any existing license or other authority or any of the existing civil actions, rights, contracts or liabilities of the converting mutual insurer. The converted stock insurer retains all property, debts and choices in action and every other interest belonging to the converting mutual insurer before the conversion without further action needed. On and after the effective date of the conversion, the converted stock insurer may exercise all rights and powers conferred and shall perform all duties imposed by law on insurers writing the classes of insurance written by the converted stock insurer, shall retain the rights and contracts of the converting mutual insurer existing immediately before the conversion and shall be subject to all obligations and liabilities of the converting mutual insurer existing immediately before the conversion, subject to the terms of the plan.

B. Any intermediate stock holding company created at the time of reorganization to hold the stock of the converting mutual insurer shall be incorporated under Title 18 of the Oklahoma Statutes and may engage in any business or activity permitted by Title 18 of the Oklahoma Statutes.

C. The converted stock insurer and any intermediate stock holding company may issue to third parties debt securities, stock other than voting stock, and voting stock if all of the following apply:

1. No shares of stock representing a majority of the voting power of all issued and outstanding voting stock of either the converted stock insurer or the intermediate stock holding company, if any, are issued to third parties; and

2. A majority of the voting stock of the converted stock insurance company is at all times owned by the mutual holding company or by the intermediate stock holding company, a majority of whose voting stock is held by the mutual holding company, and such majority interest in the converted stock insurance company and any intermediate stock holding company is not conveyed, transferred,

assigned, pledged, subjected to a security interest or lien, placed in a voting trust, encumbered or otherwise hypothecated or alienated by the mutual holding company or by the intermediate stock holding company. Any conveyance, transfer, assignment, pledge, security interest, lien, placement in a voting trust, encumbrance or hypothecation or alienation of, in or on a majority of the voting shares of the converted stock insurer or the intermediate stock holding company in violation of this paragraph is void in inverse chronological order as to the shares necessary to constitute a majority of such voting stock.

D. Unless otherwise specified in the plan, the directors and officers of the converting mutual insurer shall serve as directors and officers of the mutual holding company, any intermediate stock holding company and the converted stock insurer until new directors and officers are elected.

Added by Laws 2024, c. 194, § 2, eff. Nov. 1, 2024.

§36-660.3. Reorganization – Filing of documents – Approval by Commissioner.

A. A domestic mutual insurer may engage in a conversion as part of a reorganization as a mutual holding company, only if the board passes a resolution that the reorganization is fair and equitable to the policyholders and adopts a plan that meets the requirements of this act.

B. After the board has adopted a plan and before the board seeks approval of the plan by the eligible members of the converting mutual insurer, the converting mutual insurer shall file the following documents with the Oklahoma Insurance Commissioner:

1. The plan of reorganization;
2. The form of notice of the meeting at which the eligible members vote on the plan;
3. The form of any proxies to be solicited from the eligible members. Proxies must offer the eligible members the option of voting in favor of or voting against the plan or abstaining from voting;
4. Information required by the converting mutual insurer's bylaws; and
5. Other information or documentation required by the Commissioner.

C. The Commissioner shall approve or disapprove a plan and other documents submitted under subsection B of this section and as prescribed in Section 5 of this act. The Commissioner must approve or disapprove the plan within sixty (60) days after the Commissioner receives a completed filing of the plan and all information requested by the Commissioner or within sixty (60) days after the completion of a hearing on the plan, whichever date is later.

D. At any time before the Commissioner approves a plan, the board may amend or withdraw the plan.

E. After the Commissioner approves a plan, the eligible members of the converting mutual insurer must approve the plan. Approval by the eligible members is subject to the following requirements:

1. All eligible members must be given notice of the plan and of their opportunity to vote on the plan. A copy of the plan or a summary of the plan must accompany the notice. The notice shall be mailed to the last known address of each eligible member, as shown on the records of the converting mutual insurer, within forty-five (45) days after the Commissioner approves the plan. The meeting of the eligible members at which a vote on the plan will occur shall be set for a date that is not earlier than the thirtieth day after the date on which the mutual insurer mailed the notice of the meeting. If the converting mutual insurer complies substantially and in good faith with the notice requirements of this paragraph, the converting mutual insurer's failure to give any member or members any required notice does not impair the validity of any action taken under this section; and

2. The vote required for approval must be conducted in accordance with the converting mutual insurer's bylaws, except as follows:

- a. only eligible members may vote on the plan,
- b. an eligible member may vote in person or by proxy at the meeting at which the plan is voted on, and
- c. the plan is approved by the eligible members on the affirmative vote of two-thirds (2/3) or more of the eligible members voting on the plan, unless the bylaws require a greater number of affirmative votes. The converting mutual insurer shall file with the Commissioner a certification that the plan of reorganization has been duly adopted by a vote of at least two-thirds (2/3) of the eligible members.

F. The plan shall be carried out in accordance with its terms on the effective date of the reorganization.

G. Except as otherwise provided in this section, all information and documents obtained by or disclosed to the Commissioner or any other person in the course of preparing, filing and processing an application to reorganize, other than information and documents distributed to policyholders or filed and submitted as evidence in connection with a public hearing held pursuant to Section 5 of this act, are confidential and not subject to subpoena and shall not be made public except to insurance departments of other states, with the prior written consent of the insurer to which such information and documents pertain.

Added by Laws 2024, c. 194, § 3, eff. Nov. 1, 2024.

§36-660.4. Reorganization plan – requirements.

A plan of reorganization of a domestic mutual insurer shall include all of the following:

1. A statement of the reasons for the proposed action;
 2. A description of how the plan will be carried out, including any transaction included within the plan and a description of any mutual holding company, intermediate stock holding company or other corporation organized pursuant to the plan;
 3. A description of all significant terms of the reorganization;
 4. New or revised intercompany agreements;
 5. A description of the overall effect of the plan on policies issued by the converting mutual insurer. The description must show that policyholder interests collectively are properly preserved and protected and that the plan is fair and equitable to the policyholders;
 6. The record date for determining whether a member of the converting mutual insurer is an eligible member;
 7. The proposed effective date of the reorganization or the manner in which the proposed effective date of the reorganization is established;
 8. The proposed amendments to or restatement of the articles of incorporation and bylaws of the converting mutual insurer and the proposed articles of incorporation and bylaws of any mutual holding company, intermediate stock holding company or other corporation organized pursuant to the plan;
 9. A description of any plans for the initial sale of voting stock to third parties by the converted stock insurer or any intermediate stockholding company, or a statement that the converted stock insurer or intermediate stock holding company has no current plans for the sale of voting stock;
 10. The intention, if any, that a director or officer of the converting mutual insurer, mutual holding company, intermediate stock holding company or other corporation organized pursuant to the plan, within the six-month period following the effective date of the conversion or reorganization, may purchase or acquire shares of capital stock or other securities of an issuer to be issued pursuant to the plan; and
 11. A provision that all policies in force on the effective date of the conversion or reorganization will remain in force under the terms of those policies and that on the effective date of the reorganization, any voting rights of the members provided for under the policies or under this title are extinguished.
- Added by Laws 2024, c. 194, § 4, eff. Nov. 1, 2024.

§36-660.5. Commissioner review.

A. The Oklahoma Insurance Commissioner shall review a plan of reorganization that is submitted to the Commissioner. On review, the Commissioner shall approve the plan if the Commissioner finds all of the following:

1. The applicable provisions of this act, and other applicable provisions of law, have been fully met;

2. The plan protects the rights of policyholders;

3. The plan is fair and equitable to the members and the plan does not prejudice the interests of the members;

4. The converted stock insurer has capital or surplus, or any combination thereof, that is required of a domestic stock insurer on initial authorization to transact like kinds of insurance, and otherwise is able to satisfy the requirements of this state for transacting its insurance business;

5. The plan does not substantially reduce the security of the policyholders and the service to be rendered to the policyholders;

6. The financial condition of the mutual holding company or any subsidiary of the mutual holding company does not jeopardize the financial stability of the converted stock insurer;

7. The financial condition of the converting mutual insurer is not jeopardized by the conversion or reorganization, and the conversion or reorganization does not jeopardize the financial stability of the mutual holding company or any subsidiary of the mutual holding company; and

8. The competence, experience and integrity of those persons who control the operation of the converted stock insurer are not contrary to the interests of policyholders of the converted stock insurer and of the public in allowing the plan to proceed.

B. To the extent the plan contains a provision that allows for the acquisition or merger of other insurance companies, the Commissioner shall gauge the effect of the merger or other acquisition of control and whether it would substantially lessen competition in the insurance industry in this state or tend to create a monopoly. The Commissioner shall not approve a plan that fails to meet this standard.

C. An approval of a plan by the Commissioner expires if the plan is not carried out within one (1) year after the date of the approval, unless the Commissioner extends the time period for good cause on written application for such extension.

D. The Commissioner may retain, at the expense of the converting mutual insurer, qualified experts not otherwise a part of the staff of the Department to assist in reviewing the plan and supplemental documents.

E. The Commissioner may hold a hearing for the purposes of receiving comments on whether a plan should be approved and on any other matter relating to the reorganization. The hearing, if held, shall be held within sixty (60) days after the Commissioner receives

a completed filing of the plan and all information required by the Commissioner.

Added by Laws 2024, c. 194, § 5, eff. Nov. 1, 2024.

§36-660.6. Mutual holding company – Jurisdiction – Member rights and obligations.

A. A mutual holding company is not an insurer for the purposes of this act.

B. A mutual holding company may not dissolve or liquidate without approval by the Oklahoma Insurance Commissioner or unless required by judicial order. The Commissioner retains jurisdiction over a mutual holding company, any intermediate stock holding company, and any subsidiary of an intermediate stock holding company as provided in this act.

C. The members of a mutual holding company have the rights and obligations set forth in this act and in the articles of incorporation and bylaws of the mutual holding company. A member of a mutual holding company may not transfer membership in the mutual holding company or any right arising from such membership. Such limitation on the transfer of membership or rights arising from membership does not restrict the assignment of a policy that is otherwise permissible. A member of a mutual holding company is not personally liable for the acts, debts, liabilities or obligations of the mutual holding company merely by reason of being a member. An assessment of any kind may not be imposed on a member of a mutual holding company. Any premium due under an insurance policy or contract issued to a member of a mutual holding company is not considered an assessment.

D. A membership interest in a mutual holding company does not constitute a security.

E. Each member of a mutual holding company is entitled to one vote on each matter coming before a meeting of the members and for each director to be elected regardless of the number of policies or amount of insurance and benefits held by such member. The mutual holding company's bylaws shall set forth the voting rights of the members of a mutual holding company.

F. Meetings of the members of a mutual holding company shall be governed in the same manner as if the mutual holding company were a domestic mutual insurer, including provisions governing quorum requirements, the approval of matters by the members and the election of directors by the members.

G. The articles of incorporation of a mutual holding company shall contain all the following provisions:

1. The name of the mutual holding company. The name shall include the words "mutual holding company" or "mutual insurance holding company" or other words connoting the mutual character of the mutual holding company that are approved by the Commissioner;

2. A provision specifying that the mutual holding company is not authorized to issue capital stock, whether voting or nonvoting; and

3. A provision setting forth any rights of the members of the mutual holding company on dissolution or liquidation.

H. A mutual holding company shall automatically be a party to any rehabilitation or liquidation proceeding involving the converted stock insurer that, as a result of a reorganization, is a direct or indirect subsidiary of the mutual holding company. In such a proceeding, the assets of the mutual holding company shall be counted as assets of the estate of the converted stock insurer for the purpose of satisfying the claims of the policyholders of the converted stock insurer.

Laws 2024, c. 194, § 6, eff. Nov. 1, 2024.

§36-660.7. Multiple mutual insurers – Joint application and plan.

The concurrent reorganization of a domestic mutual insurer with one or more mutual insurers, domestic or foreign, into a single mutual insurance holding company, whether domestic or foreign, may be accomplished by a joint application and a joint plan of reorganization and may be approved by the Oklahoma Insurance Commissioner by complying with the requirements of this act. The Commissioner may determine that such other procedures are unnecessary to avoid duplicative costs and efforts in satisfying the requirements of this act and effectuating the reorganization.

Added by Laws 2024, c. 194, § 7, eff. Nov. 1, 2024.

§36-660.8. Converting insurer – Holding company formation – Rights and obligations.

A. A converting company, on approval by the Oklahoma Insurance Commissioner, may reorganize by forming a holding company based on a mutual plan and continuing the corporate existence of the converting company as a stock insurance company.

B. A mutual holding company is automatically a party to an administrative proceeding under Oklahoma Statute involving an insurance company that, as a result of a reorganization under this act, is a subsidiary of the mutual holding company. In a proceeding involving the resulting company, the assets of the mutual holding company are considered assets of the resulting company for purposes of satisfying the claims of the resulting company's policyholders.

C. A mutual holding company may not dissolve or liquidate without the approval of the Commissioner.

D. A mutual holding company may convert to a stock holding company under this act as if the mutual holding company were a mutual insurance company.

Added by Laws 2024, c. 194, § 8, eff. Nov. 1, 2024.

§36-660.9. Proposed reorganization plan – Commissioner review as alternate conversion plan.

A. The Oklahoma Insurance Commissioner shall review the proposed plan of reorganization as an alternate conversion plan. The Commissioner may require as a condition of approval modifications of the proposed plan of reorganization that the Commissioner determines necessary to protect the members' interests.

B. The Commissioner may retain at the mutual insurance company's expense, a qualified expert who is not a member of the Commissioner's staff to assist the Commissioner in reviewing the conversion plan and the valuation. If the Commissioner retains a qualified expert under this subsection, the Commissioner may extend the period for decision by an additional sixty (60) days beyond the initial sixty-day period.

C. The Commissioner has jurisdiction over a mutual holding company organized under this act to ensure that member interests are protected.

Added by Laws 2024, c. 194, § 9, eff. Nov. 1, 2024.

§36-660.10. Organization of mutual holding company – Requirements.

A mutual holding company that results from the reorganization of a domestic mutual insurance company organized under this act must be organized in accordance with Title 18 of the Oklahoma Statutes. The articles of incorporation, and any amendments to those articles, of the mutual holding company are subject to approval of the Oklahoma Insurance Commissioner in the same manner as those of a mutual insurance company.

Added by Laws 2024, c. 194, § 10, eff. Nov. 1, 2024.

§36-660.11. Policyholder membership interests.

A. The membership interests of the policyholders of the resulting company become membership interests in the mutual holding company. Eligible members of the converting company become members of the mutual holding company in accordance with the articles of incorporation and bylaws of the mutual holding company.

B. A membership interest in a mutual holding company does not constitute a security, defined as:

1. A limited partner interest in a limited partnership;
2. A share;
3. A stock;
4. A treasury stock;
5. A stock certificate under a voting trust agreement;
6. A collateral trust certificate;
7. An equipment trust certificate;
8. A preorganization certificate or receipt;
9. A subscription or reorganization certificate;

10. A note, bond, debenture, mortgage certificate, or other evidence of indebtedness;

11. Any form of commercial paper;

12. A certificate in or under a profit-sharing or participation agreement;

13. A certificate or instrument representing an interest in or under an oil, gas, or mining lease, fee, or title;

14. A certificate or instrument representing or secured by an interest in any of the capital, property, assets, profits, or earnings of a company;

15. An investment contract; and

16. Any other instrument commonly known as a security, regardless of whether the instrument is similar to another instrument listed in this subsection.

This applies regardless of whether the security is evidenced by a written instrument. This definition does not include an insurance policy, endowment policy, annuity contract, or optional annuity contract, or any contract or agreement in relation to and in consequence of any such policy or contract, issued by an insurance company subject to the supervision or control of the Oklahoma Insurance Department when the form of such policy or contract has been filed with the Department as required by law.

Added by Laws 2024, c. 194, § 11, eff. Nov. 1, 2024.

§36-660.12. Initial shares – Majority of voting shares.

A. As used in this section:

1. "Intermediate holding company" means a holding company that:

a. is a subsidiary of a mutual holding company formed to reorganize a mutual insurance company, and

b. directly or through a subsidiary intermediate holding company, owns the resulting company; and

2. "Majority of the voting shares of the capital stock" means shares of the capital stock of a company that carry the right to cast a majority of the votes entitled to be cast by all of the outstanding shares of the capital stock of the company on all matters submitted to a vote of the shareholders of the company.

B. All of the initial shares of the capital stock of the resulting company shall be issued to the mutual holding company.

C. The mutual holding company shall at all times own a majority of the voting shares of the capital stock of the resulting company or of an intermediate holding company established to hold the voting shares of the resulting company. The requirements of this subsection may be satisfied by indirect ownership through one or more intermediate holding companies in a corporate structure approved by the Oklahoma Insurance Commissioner.

D. The mutual holding company or intermediate holding company may not convey, transfer, assign, pledge, subject to a security

interest or lien, encumber, or otherwise hypothecate or alienate the majority of the voting shares of the capital stock that is required to be owned under subsection C of this section.

E. A violation of subsection D of this section is void in inverse chronological order from the date of the conveyance or activity as to the shares necessary to constitute a majority of the voting shares of the capital stock.

Added by Laws 2024, c. 194, § 12, eff. Nov. 1, 2024.

§36-660.13. Foreign mutual insurance company – Reorganization requirements.

A. On the approval of the Oklahoma Insurance Commissioner, a foreign mutual insurance company may reorganize in compliance with the requirements of any law or regulation applicable to the foreign mutual insurance company by:

1. Transferring its members' membership interests into a mutual holding company formed under a procedure analogous to that described by this act; and

2. Continuing the corporate existence of the reorganizing foreign mutual insurance company as a foreign stock insurance company subsidiary of the mutual holding company.

B. The reorganizing foreign mutual insurance company may remain a foreign company and may be admitted to do business in this state. A foreign mutual insurance company may also redomesticate in this state by complying with the applicable requirements of Section 606.1 of Title 36 of the Oklahoma Statutes.

Added by Laws 2024, c. 194, § 13, eff. Nov. 1, 2024.

§36-670. Short title – Insurance Data Security Act.

This act shall be known and may be cited as the "Insurance Data Security Act".

Added by Laws 2024, c. 346, § 1, eff. July 1, 2024.

§36-671. Construction and application of act.

A. Notwithstanding any other provision of law, the provisions of this act shall be the exclusive state law for licensees subject to the jurisdiction of the Insurance Commissioner for data security, the investigation of a cybersecurity event, and notification to the Commissioner.

B. This act shall not be construed to create or imply a private cause of action for violations of its provisions.

Added by Laws 2024, c. 346, § 2, eff. July 1, 2024.

§36-672. Definitions.

As used in this act:

1. "Authorized individual" means an individual known to and screened by the licensee and determined to be necessary and

appropriate to have access to the nonpublic information held by the licensee and its information systems;

2. "Commissioner" means the Insurance Commissioner;

3. "Consumer" means an individual, including but not limited to applicants, policyholders, insureds, beneficiaries, claimants, and certificate holders, who is a resident of this state and whose nonpublic information is in the possession, custody, or control of a licensee;

4. "Cybersecurity event" means an event resulting in unauthorized access to or disruption or misuse of an information system or nonpublic information stored on the information system. The term cybersecurity event shall not include the unauthorized acquisition of encrypted nonpublic information if the encryption, process, or key is not also acquired, released, or used without authorization. Cybersecurity event shall not include an event in which the licensee has determined that the nonpublic information accessed by an unauthorized person has not been used or released and has been returned or destroyed;

5. "Department" means the Insurance Department;

6. "Encrypted" means the transformation of data into a form which results in a low probability of assigning meaning without the use of a protective process or key;

7. "Information security program" means the administrative, technical, and physical safeguards that a licensee uses to access, collect, distribute, process, protect, store, use, transmit, dispose of, or otherwise handle nonpublic information;

8. "Information system" means a discrete set of electronic information resources organized for the collection, processing, maintenance, use, sharing, dissemination or disposition of nonpublic information, as well as any specialized system such as industrial or process controls systems, telephone switching and private branch exchange systems, and environmental control systems;

9. "Licensee" means any person licensed, authorized to operate, or registered, or required to be licensed, authorized to operate, or registered, pursuant to Title 36 of the Oklahoma Statutes; provided, however, that it shall not include a purchasing group or a risk retention group chartered and licensed in a state other than this state or a person that is acting as an assuming insurer that is domiciled in another state or jurisdiction;

10. "Multi-factor authentication" means authentication through verification of at least two (2) of the following types of authentication factors:

- a. knowledge factors, such as a password,
- b. possession factors, such as a token or text message on a mobile phone, or
- c. inherence factors, such as a biometric characteristic;

11. "Nonpublic information" means electronic information that is not publicly available and is:

- a. business related information of a licensee, of which the tampering with or unauthorized disclosure, access, or use of would cause a material adverse impact to the business, operations, or security of the licensee,
- b. any information concerning a consumer that, because of name, number, personal mark, or other identifier, can be used to identify him or her, in combination with any one or more of the following data elements:
 - (1) social security number,
 - (2) driver license number or nondriver identification card number,
 - (3) financial account number, credit card number, or debit card number,
 - (4) any security code, access code, or password that would permit access to a consumer's financial account, or
 - (5) biometric records, or
- c. any information or data, except age or gender, in any form or medium created by or derived from a health care provider or a consumer that can be used to identify a particular consumer and that relates to:
 - (1) the past, present, or future physical, mental, or behavioral health or condition of any consumer or a member of the family of the consumer,
 - (2) the provision of health care to any consumer, or
 - (3) payment for the provision of health care to any consumer;

12. "Person" means any individual or any nongovernmental entity including, but not limited to, any nongovernmental partnership, corporation, branch, agency, or association;

13. "Publicly available information" means any information that a licensee has reasonable basis to believe is lawfully made available to the general public from federal, state, or local government records, widely distributed media, or disclosures to the general public that are required to be made by federal, state, or local law. For the purposes of this definition, a licensee has a reasonable basis to believe that information is lawfully made available to the general public if the licensee has taken steps to determine:

- a. that the information is of the type that is available to the general public, and
- b. whether a consumer can direct that the information not be made available to the general public and, if so, that such consumer has not done so; and

14. "Third-party service provider" means a person, not otherwise defined as a licensee, that contracts with a licensee to maintain, process, store, or otherwise is permitted access to nonpublic information through its provision of services to the licensee.

Added by Laws 2024, c. 346, § 3, eff. July 1, 2024.

§36-673. Information security program.

A. Each licensee in this state shall develop, implement, and maintain a comprehensive written information security program based on the risk assessment of the licensee provided for in this act and that contains administrative, technical, and physical safeguards for the protection of nonpublic information and the information systems of the licensee. The program shall be commensurate with the size and complexity of the licensee, the nature and scope of the activities of the licensee, including its use of third-party service providers, and the sensitivity of the nonpublic information used by the licensee or in the possession, custody, or control of the licensee.

B. An information security program of a licensee shall be designed to:

1. Protect the security and confidentiality of nonpublic information and the security of the information systems;

2. Protect against any threats or hazards to the security or integrity of nonpublic information and the information systems;

3. Protect against unauthorized access to or use of nonpublic information, and minimize the likelihood of harm to any consumer; and

4. Define and periodically reevaluate a schedule for retention of nonpublic information and a mechanism for its destruction when no longer needed.

C. The licensee shall:

1. Designate one or more employees, an affiliate, or an outside vendor designated to act on behalf of the licensee who is responsible for the information security program;

2. Identify reasonably foreseeable internal or external threats that could result in unauthorized access, transmission, disclosure, misuse, alteration, or destruction of nonpublic information including, but not limited to, the security of information systems and nonpublic information that are accessible to, or held by, third-party service providers;

3. Assess the likelihood and potential damage of these threats, taking into consideration the sensitivity of the nonpublic information;

4. Assess the sufficiency of policies, procedures, information systems, and other safeguards in place to manage these threats,

including consideration of threats in each relevant area of the operations of the licensee, including:

- a. employee training and management,
- b. information systems, including, but not limited to, network and software design, as well as information classification, governance, processing, storage, transmission, and disposal, and
- c. detecting, preventing, and responding to attacks, intrusions, or other systems failures; and

5. Implement information safeguards to manage the threats identified in its ongoing assessment, and no less than annually, assess the effectiveness of the key controls, systems, and procedures of the safeguards.

D. Based on the results of the risk assessment, the licensee shall:

1. Design its information security program to mitigate the identified risks, commensurate with the size and complexity of the licensee, the nature and scope of the activities of the licensee including its use of third-party service providers, and the sensitivity of the nonpublic information used by the licensee or in the possession, custody, or control of the licensee;

2. Determine and implement security measures deemed appropriate, including:

- a. place access controls on information systems including controls to authenticate and permit access only to authorized individuals to protect against the unauthorized acquisition of nonpublic information,
- b. identify and manage the data, personnel, devices, systems, and facilities that enable the organization to achieve business purposes in accordance with their relative importance to business objectives and the risk strategy of the organization,
- c. restrict physical access to nonpublic information to authorized individuals only,
- d. protect by encryption or other appropriate means, all nonpublic information while being transmitted over an external network and all nonpublic information stored on a laptop computer or other portable computing or storage device or media,
- e. adopt secure development practices for in-house developed applications utilized by the licensee,
- f. modify the information system in accordance with the information security program of the licensee,
- g. utilize effective controls, which may include multi-factor authentication procedures for any authorized individual accessing nonpublic information,

- h. regularly test and monitor systems and procedures to detect actual and attempted attacks on, or intrusions into, information systems,
- i. include audit trails within the information security program designed to detect and respond to cybersecurity events and designed to reconstruct material financial transactions sufficient to support normal operations and obligations of the licensee,
- j. implement measures to protect against destruction, loss, or damage of nonpublic information due to environmental hazards such as fire and water damage or other catastrophic events or technological failures, and
- k. develop, implement, and maintain procedures for the secure disposal of nonpublic information in any format;

3. Include cybersecurity risks in the enterprise risk management process of the licensee;

4. Stay informed regarding emerging threats or vulnerabilities and utilize reasonable security measures when sharing information relative to the character of the sharing and the type of information shared; and

5. Provide its personnel with cybersecurity awareness training that is updated as necessary to reflect risks identified by the licensee in the risk assessment.

E. If the licensee has a board of directors, the board or an appropriate committee of the board, at a minimum, within one year of the effective date of this act, shall:

1. Require the executive management of the licensee or its delegates to develop, implement, and maintain the information security program of the licensee;

2. Require the executive management of the licensee or its delegates to report to the Insurance Commissioner in writing, at least annually, the following information:

- a. the overall status of the information security program and the compliance of the licensee with this act, and
- b. material matters related to the information security program, addressing issues such as risk assessment, risk management and control decisions, third-party service provider arrangements, results of testing, cybersecurity events or violations and responses of the management to those events or violations, and recommendations for changes in the information security program; and

3. If executive management delegates any of its responsibilities, it shall oversee the development, implementation, and maintenance of the information security program of the licensee

prepared by the delegate or delegates and shall receive a report from the delegate or delegates complying with the requirements of the report to the board.

F. A licensee shall exercise due diligence in selecting its third-party service provider and shall require the provider to implement appropriate administrative, technical, and physical measures to protect and secure the information systems and nonpublic information that are accessible to, or held by, the third-party service provider.

G. The licensee shall monitor, evaluate, and adjust, as appropriate, the information security program consistent with any relevant changes in technology, the sensitivity of its nonpublic information, internal or external threats to information and the changing business arrangements of the licensee, such as mergers and acquisitions, alliances and joint ventures, outsourcing arrangements, and changes to information systems.

H. As part of its information security program, each licensee shall establish a written incident response plan designed to promptly respond to, and recover from, any cybersecurity event that compromises the confidentiality, integrity, or availability of nonpublic information in its possession, the information systems of the licensee, or the continuing functionality of any aspect of the business or operations of the licensee.

The incident response plan shall address the following areas:

1. The internal process for responding to a cybersecurity event;
2. The goals of the incident response plan;
3. The definition of clear roles, responsibilities, and levels of decision-making authority;
4. External and internal communications and information sharing;
5. Identification of requirements for the remediation of any identified weaknesses in information systems and associated controls;
6. Documentation and reporting regarding cybersecurity events and related incident response activities; and
7. The evaluation and revision as necessary of the incident response plan following a cybersecurity event.

I. Annually, each insurer domiciled in this state shall submit to the Commissioner a written statement by April 15, certifying that the insurer complies with the requirements set forth in this section. Each insurer shall maintain, for examination by the Insurance Department, all records, schedules, and data supporting this certificate for a period of five (5) years. To the extent an insurer has identified areas, systems, or processes that require material improvement, updating, or redesign, the insurer shall document the identification and the remedial efforts planned and

underway to address such areas, systems, or processes. The documentation shall be available for inspection by the Commissioner upon request.

Added by Laws 2024, c. 346, § 4, eff. July 1, 2024.

§36-674. Cybersecurity event – Investigation by licensee.

A. If the licensee learns that a cybersecurity event has or may have occurred, the licensee, or an outside vendor or service provider designated to act on behalf of the licensee, shall conduct a prompt investigation.

B. During the investigation, the licensee, or an outside vendor or service provider designated to act on behalf of the licensee, shall, at a minimum:

1. Determine whether a cybersecurity event has occurred;
2. Assess the nature and scope of the cybersecurity event;
3. Identify any nonpublic information that may have been involved in the cybersecurity event; and
4. Perform or oversee reasonable measures to restore the security of the information systems compromised in the cybersecurity event in order to prevent further unauthorized acquisition, release, or use of nonpublic information in the possession, custody, or control of the licensee.

C. If the licensee learns that a cybersecurity event has or may have occurred in a system maintained by a third-party service provider, the licensee shall complete the steps listed in subsection B of this section or confirm and document that the third-party service provider has completed those steps.

D. The licensee shall maintain records concerning all cybersecurity events for a period of at least five (5) years from the date of the cybersecurity event and shall produce those records upon request by the Insurance Commissioner.

Added by Laws 2024, c. 346, § 5, eff. July 1, 2024.

§36-675. Notification of cybersecurity event – Required information.

A. Every licensee shall notify the Insurance Commissioner without unreasonable delay, but not later than three business days, from a determination that a cybersecurity event involving nonpublic information that is in the possession of a licensee has occurred when either of the following criteria has been met:

1. This state is the state of domicile of the licensee, in the case of an insurer, or this state is the home state of the licensee, in the case of a producer, as those terms are defined in the Oklahoma Producer Licensing Act, Sections 1435.1 through 1435.41 of Title 36 of the Oklahoma Statutes, and the cybersecurity event has a reasonable likelihood of materially harming any material part of the

normal operations of the licensee or any consumer residing in this state; or

2. The licensee reasonably believes that the nonpublic information involved is of two hundred fifty (250) or more consumers residing in this state and is either of the following:

- a. a cybersecurity event impacting the licensee of which notice is required to be provided to any government body, self-regulatory agency, or any other supervisory body pursuant to any state or federal law, or
- b. a cybersecurity event that has a reasonable likelihood of materially harming:
 - (1) any consumer residing in this state, or
 - (2) any material part of the normal operation or operations of the licensee.

B. The licensee making the notification required in subsection A of this section shall provide as much of the following information as possible, electronically in the manner and form prescribed by the Commissioner, along with any applicable fees. The licensee shall have a continuing obligation to update and supplement initial and subsequent notifications to the Commissioner regarding material changes to previously provided information relating to the cybersecurity event. The licensee shall provide:

1. Date of the cybersecurity event;
2. Description of how the information was exposed, lost, stolen, or breached including, but not limited to, the specific roles and responsibilities of third-party service providers, if any;
3. How the cybersecurity event was discovered;
4. Whether any lost, stolen, or breached information has been recovered and, if so, how this was done;
5. The identity of the source of the cybersecurity event;
6. Whether the licensee has filed a police report or has notified any regulatory, government, or law enforcement agencies and, if so, when such notification was provided;
7. Description of the specific types of information acquired without authorization. The term "specific types of information" means particular data elements including, but not limited to, types of medical information, financial information, or information allowing identification of the consumer;
8. The period during which the information system was compromised by the cybersecurity event;
9. The number of total consumers in this state affected by the cybersecurity event. The licensee shall provide the best estimate in the initial report to the Commissioner and update this estimate with each subsequent report to the Commissioner pursuant to this section;

10. The results of any internal review identifying a lapse in either automated controls or internal procedures, or confirming that all automated controls or internal procedures were followed;

11. Description of efforts being undertaken to remediate the situation which permitted the cybersecurity event to occur;

12. A copy of the privacy policy of the licensee and a statement outlining the steps the licensee will take to investigate and notify consumers affected by the cybersecurity event; and

13. Name of a contact person who is both familiar with the cybersecurity event and authorized to act for the licensee.

C. A licensee shall comply with the procedures of the Security Breach Notification Act, Section 161 et seq. of Title 24 of the Oklahoma Statutes, to notify affected consumers and provide a copy of the notice sent to consumers under that statute to the Commissioner, when a licensee is required to notify the Commissioner under subsection A of this section.

D. 1. In the case of a cybersecurity event in a system maintained by a third-party service provider, of which the licensee has become aware, the licensee shall treat the event as it would under subsection A of this section unless the third-party service provider provides the notice required under subsection A of this section to the Commissioner and the licensee.

2. The computation of deadlines of the licensee shall begin on the day after the third-party service provider notifies the licensee of the cybersecurity event or the licensee otherwise has actual knowledge of the cybersecurity event, whichever is sooner.

3. Nothing in this act shall prevent or abrogate an agreement between a licensee and another licensee, a third-party service provider, or any other party to fulfill any of the investigation requirements or notice requirements imposed under this act.

E. 1. In the case of a cybersecurity event involving nonpublic information that is used by the licensee that is acting as an assuming insurer, or in the possession, custody, or control of a licensee, that is acting as an assuming insurer and that does not have a direct contractual relationship with the affected consumers, the assuming insurer shall notify its affected ceding insurers and the Commissioner of its state of domicile within three (3) business days of making the determination that a cybersecurity event has occurred. The ceding insurers that have a direct contractual relationship with affected consumers shall fulfill the consumer notification requirements imposed under the Security Breach Notification Act, Section 161 et seq. of Title 24 of the Oklahoma Statutes, and any other notification requirements relating to a cybersecurity event imposed under this section.

2. In the case of a cybersecurity event involving nonpublic information that is in the possession, custody, or control of a third-party service provider of a licensee that is an assuming

insurer, the assuming insurer shall notify its affected ceding insurers and the Commissioner of its state of domicile within three (3) business days of receiving notice from its third-party service provider that a cybersecurity event has occurred. The ceding insurers that have a direct contractual relationship with affected consumers shall fulfill the consumer notification requirements imposed under Security Breach Notification Act, Section 161 et seq. of Title 24 of the Oklahoma Statutes, and any other notification requirements relating to a cybersecurity event imposed under this section.

F. In the case of a cybersecurity event involving nonpublic information that is in the possession, custody, or control of a licensee that is an insurer or its third-party service provider for which a consumer accessed the services of the insurer through an independent insurance producer, and for which consumer notice is required by this act or the Security Breach Notification Act, Section 161 et seq. of Title 24 of the Oklahoma Statutes, the insurer shall notify the producers of record of all affected consumers of the cybersecurity event no later than the time at which notice is provided to the affected consumers. The insurer is excused from this obligation for any producers who are not authorized by law or contract to sell, solicit, or negotiate on behalf of the insurer, and in those instances in which the insurer does not have the current producer of record information for an individual consumer. Any licensee acting as an assuming insurer shall have no other notice obligations relating to a cybersecurity event or other data breach under this section or any other law of this state.

Added by Laws 2024, c. 346, § 6, eff. July 1, 2024.

§36-676. Commissioner power to investigate.

A. The Insurance Commissioner shall have power to examine and investigate the affairs of any licensee to determine whether the licensee has been or is engaged in any conduct in violation of the provisions of this act or any rules promulgated thereto. This power is in addition to the powers which the Commissioner has under applicable provisions of the Insurance Code including, but not limited to, Sections 309.1 through 309.6, 332, and 1250.4 of Title 36 of the Oklahoma Statutes.

B. Whenever the Commissioner has reason to believe that a licensee has been or is engaged in conduct in this state that violates any provision of this act, the Commissioner may take action that is necessary or appropriate to enforce the provisions.

Added by Laws 2024, c. 346, § 7, eff. July 1, 2024.

§36-677. Confidential information.

A. Any documents, materials, or other information in the control or possession of the Insurance Department that are furnished by a licensee or an employee or agent thereof acting on behalf of a licensee pursuant to the provisions of Section 4 and Section 6 of this act or that are obtained by the Insurance Commissioner in an investigation or examination pursuant to Section 7 of this act shall be confidential by law and privileged, shall not be subject to the Oklahoma Open Records Act, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the Commissioner is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the Commissioner's duties. The Commissioner shall not otherwise make the documents, materials, or other information public without the prior written consent of the licensee.

B. Neither the Commissioner nor any person who received documents, materials, or other information while acting under the authority of the Commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subsection A of this section.

C. In order to assist in the performance of the duties of the Commissioner under this act, the Commissioner:

1. May share documents, materials, or other information including the confidential and privileged documents, materials, or information subject to subsection A of this section, with other state, federal, and international regulatory agencies, with the National Association of Insurance Commissioners and its affiliates or subsidiaries and with state, federal, and international law enforcement authorities; provided, that the recipient agrees in writing to maintain the confidentiality and privileged status of the document, material, or other information;

2. May receive documents, materials, or information including otherwise confidential and privileged documents, materials, or information, from the National Association of Insurance Commissioners, its affiliates or subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information;

3. May share documents, materials, or other information subject to subsection A of this section, with a third-party consultant or vendor; provided, the consultant agrees in writing to maintain the confidentiality and privileged status of the document, material, or other information; and

4. May enter into agreements governing sharing and use of information consistent with this subsection.

D. No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the Insurance Commissioner under this section or as a result of sharing as authorized in subsection C of this section.

E. Nothing in this act shall prohibit the Commissioner from releasing final, adjudicated actions that are open to public inspection pursuant to the Oklahoma Open Records Act, to a database or other clearinghouse service maintained by the National Association of Insurance Commissioners, its affiliates, or subsidiaries.

F. Documents, materials, or other information in the possession or control of the National Association of Insurance Commissioners or a third-party consultant or vendor pursuant to this act shall not be construed to be public information, shall not be subject to the Oklahoma Open Records Act, shall not be subject to subpoena, and shall not be subject to discovery or admissible as evidence in any private civil action.

Added by Laws 2024, c. 346, § 8, eff. July 1, 2024.

§36-678. Promulgation of rules – Violations.

A. The Insurance Commissioner may promulgate any rules necessary to carry out the provisions of this section.

B. 1. The following exceptions shall apply to this act:

- a. a licensee with less than Five Million Dollars (\$5,000,000.00) in gross annual revenue, is exempt from this act,
- b. a licensee subject to the Health Insurance Portability and Accountability Act, Pub. L. 104-191, 110 Stat. 1936, as amended, that has established and maintains an information security program pursuant to such statutes, rules, regulations, procedures, or guidelines established thereunder, will be considered to meet the requirements of Section 4 of this act, provided that the licensee is compliant with and submits a written statement to the Commissioner certifying its compliance with the same,
- c. a licensee subject to Title V of the federal Gramm-Leach-Bliley Act of 1999 (15 U.S.C. Sections 6801-6809 and 6821-6827) that has established and maintains an information security program pursuant to such, statutes, rules, regulations, procedures, or guidelines established thereunder, will be considered to meet the requirements of Section 4 of this act, provided that the licensee is compliant with and

- submits a written statement to the Commissioner certifying its compliance with the same, and
- d. an employee, agent, representative, or designee of a licensee, who is also a licensee, is exempt from this act and shall not be required to develop their own information security program to the extent that the employee, agent, representative, or designee is covered by the information security program of the licensee.

2. If a licensee ceases to qualify for an exception, the licensee shall have one hundred eighty (180) days to comply with the provisions of this act.

C. In the case of a violation of this act, a licensee may be penalized in accordance with any applicable sections of the Insurance Code, including, but not limited to, Section 908 of Title 36 of the Oklahoma Statutes, or any other provision providing for penalties that the licensee is subject to under the license or permit of the licensee. Nothing in this act shall be construed to impose any civil liability for any violation of this act or omission to act by the licensee or employees of the licensee.

D. The provisions of this act shall take precedence over any other state laws applicable to licensees for data security and the investigation of a cybersecurity event.

Added by Laws 2024, c. 346, § 9, eff. July 1, 2024.

§36-679. Implementation by licensee.

Licensees shall have one (1) year from the effective date of this act to implement Section 4 of this act and two (2) years from the effective date of this act to implement subsection F of Section 4 of this act.

Added by Laws 2024, c. 346, § 10, eff. July 1, 2024.

§36-701. Definitions not mutually exclusive.

It is intended that certain coverages may come within the definitions of two or more kinds of insurance as set forth in this article, and the fact that such a coverage is included within one definition shall not exclude such coverage as to any other kind of insurance within the definition of which such coverage likewise reasonably is includable.

Laws 1957, p. 239, § 701.

§36-702. "Life insurance" defined.

"Life insurance" is insurance on human lives and insurance appertaining thereto or connected therewith. The transacting of life insurance includes the granting of endowment benefits, additional benefits in the event of death or dismemberment by accident or accidental means, additional benefits in the event of

the disability of the insured, optional modes of settlement of proceeds of life insurance, and additional benefits providing acceleration of life or endowment or annuity benefits in advance of the time they would otherwise be payable, as an indemnity for long-term care which is certified or ordered by a physician, including but not limited to, professional nursing care, medical care expenses, custodial nursing care, nonnursing custodial care provided in a nursing home or at a residence of the insured or providing such acceleration upon the occurrence of a catastrophic disease or diseases as designated and defined by the policy. An insurer authorized to transact life insurance may also grant annuities. Laws 1957, p. 239, § 702.

§36-703. "Accident and health insurance" defined.

"Accident and health insurance" is insurance against bodily injury, disablement, or death by accident or accidental means, or the expense thereof, or against disablement or expense resulting from sickness, and every insurance appertaining thereto. Laws 1957, p. 239, § 703.

§36-704. "Property insurance" defined.

"Property insurance" is insurance on real or personal property of every kind and interest therein, against loss or damage from any or all hazard or cause, and against loss consequential upon such loss or damage, other than noncontractual legal liability for any such loss or damage. Property insurance shall also include miscellaneous insurance as defined in paragraph 11 of section 707 of this article except as to any noncontractual liability coverage includable therein. Laws 1957, p. 239, § 704.

§36-705. "Marine insurance" defined.

"Marine insurance" includes:

1. Insurance against any and all kinds of loss or damage to vessels, craft, aircraft, cars, automobiles and vehicles of every kind, as well as all goods, freight, cargoes, merchandise, effects, disbursements, profits, moneys, bullion, precious stones, securities, choses in action, evidence of debt, valuable papers, bottomry and respondentia interests and all other kinds of property and interests therein, in respect to, appertaining to or in connection with any and all risks or perils of navigation, transit, or transportation, including war risks, on or under any seas or other waters, on land or in the air, or while being assembled, packed, crated, baled, compressed or similarly prepared for shipment or while awaiting the same or during any delays, storage, transshipment, or reshipment incident thereto, including marine builders' risks and all personal property floater risks;

2. Insurance against any and all kinds of loss or damage to person or to property in connection with or appertaining to a marine, inland marine, transit or transportation insurance, including liability for loss of or damage to either, arising out of or in connection with the construction, repair, operation, maintenance or use of the subject matter of such insurance (but not including life insurance or surety bonds nor insurance against loss by reason of bodily injury to the person arising out of the ownership, maintenance or use of automobiles);

3. Insurance against any and all kinds of loss or damage to precious stones, jewelry, gold, silver and other precious metals, whether used in business or trade or otherwise and whether the same be in course of transportation or otherwise;

4. Insurance against any and all kinds of loss or damage to bridges, tunnels and other instrumentalities of transportation and communication (excluding buildings, their furniture and furnishings, fixed contents and supplies held in storage) unless fire, tornado, sprinkler leakage, hail, explosion, earthquake, riot or civil commotion or any or all of them are the only hazards to be covered;

5. Insurance against any and all kinds of loss or damage to piers, wharves, docks and slips, excluding the risks of fire, tornado, sprinkler leakage, hail, explosion, earthquake, riot and civil commotion and each of them;

6. Insurance against any and all kinds of loss or damage to other aids to navigation and transportation, including dry docks and marine railways, dams and appurtenant facilities for the control of waterways; and

7. Marine protection and indemnity insurance, which is insurance against, or against legal liability of the insured for, loss, damage or expense arising out of, or incident to, the ownership, operation, chartering, maintenance, use, repair or construction of any vessel, craft or instrumentality in use in ocean or inland waterways, including liability of the insured for personal injury, illness or death or for loss of or damage to the property of another person.

Laws 1957, p. 240, § 705.

§36-706. "Vehicle insurance" defined.

"Vehicle insurance" is insurance against loss of or damage to any land vehicle or aircraft or any draft or riding animal or to property while contained therein or thereon or being loaded or unloaded therein or therefrom, from any hazard or cause, and against any loss, liability or expense resulting from or incident to ownership, maintenance or use of any such vehicle, aircraft or animal; together with insurance against accidental death or accidental injury to individuals, including the named insured, while in, entering, alighting from, adjusting, repairing, cranking, or

caused by being struck by a vehicle, aircraft or draft or riding animal, if such insurance is issued as a part of insurance on the vehicle, aircraft or draft or riding animal.
Laws 1957, p. 240, § 706.

§36-707. "Casualty insurance" defined.

"Casualty insurance" includes vehicle insurance as defined in Section 706 and accident and health insurance as defined in Section 703, of this article, and in addition includes:

1. Liability insurance, which is insurance against legal liability for the death, injury, or disability of any human being, or for damage to property; and provision of medical, hospital, surgical, disability benefits to injured persons and funeral and death benefits to dependents, beneficiaries or personal representatives of persons killed, irrespective of legal liability of the insured, when issued as an incidental coverage with or supplemental to liability insurance.
2. Workers' compensation and employers' liability insurance, which is insurance of the obligations accepted by, imposed upon, or assumed by employers for death, disablement, or injury of employees.
3. Burglary and theft insurance, which is insurance against loss or damage by burglary, theft, larceny, robbery, forgery, fraud, vandalism, malicious mischief, confiscation, or wrongful conversion, disposal, or concealment, or from any attempt at any of the foregoing, including supplemental coverages for medical, hospital, surgical, and funeral benefits sustained by the named insured or other person as a result of bodily injury during the commission of a burglary, robbery, or theft by another; also insurance against loss of or damage to monies, coins, bullion, securities, notes, drafts, acceptances, or any other valuable papers and documents, resulting from any cause.
4. Personal property floater insurance, which is insurance upon personal effects against loss or damage from any cause.
5. Glass insurance, which is insurance against loss or damage to glass, including its lettering, ornamentation, and fittings.
6. Boiler and machinery insurance, which is insurance against any liability and loss or damage to property or interest resulting from accidents to or explosion of boilers, pipes, pressure containers, machinery, or apparatus, and to make inspection of and issue certificates of inspection upon boilers, machinery, and apparatus of any kind, whether or not insured.
7. Leakage and fire extinguishing equipment insurance, which is insurance against loss or damage to any property or interest caused by the breakage or leakage of sprinklers, hoses, pumps, and other fire extinguishing equipment or apparatus, water pipes and containers, or by water entering through leaks or openings in

buildings, and insurance against loss or damage to such sprinklers, hoses, pumps, and other fire extinguishing equipment or apparatus.

8. Credit insurance, which is insurance against loss or damage resulting from failure of debtors to pay their obligations to the insured.

9. Malpractice insurance, which is insurance against legal liability of the insured, and against loss, damage, or expense incidental to a claim of such liability, and including medical, hospital, surgical, and funeral benefits to injured persons, irrespective of legal liability of the insured, arising out of the death, injury, or disablement of any person, or arising out of damage to the economic interest of any person, as the result of negligence in rendering expert, fiduciary, or professional services.

10. Entertainments insurance, which is insurance indemnifying the producer of any motion picture, television, radio, theatrical, sport, spectacle, entertainment, or similar production, event, or exhibition against loss from interruption, postponement, or cancellation thereof due to death, accidental injury, or sickness of performers, participants, directors, or other principals.

11. Miscellaneous insurance, which is insurance against any other kind of loss, damage, or liability properly a subject of insurance and not within any other kind of insurance as defined in this article, if such insurance is not disapproved by the Insurance Commissioner as being contrary to law or public policy.

Added by Laws 1957, p. 240, § 707, operative July 1, 1957.

§36-708. "Surety insurance" defined.

"Surety insurance" includes:

1. Fidelity insurance, which is insurance guaranteeing the fidelity of persons holding positions of public or private trust.

2. Insurance guaranteeing the performance of contracts, other than insurance policies, and guaranteeing and executing bonds, undertakings and contracts of suretyship.

3. Insurance indemnifying banks, bankers, brokers, financial or moneyed corporations or associations against loss, resulting from any cause, of bills of exchange, notes, bonds, securities, evidences of debt, deeds, mortgages, warehouse receipts or other valuable papers, documents, money, precious metals and articles made therefrom, jewelry, watches, necklaces, bracelets, gems, precious and semiprecious stones, including any loss while the same are being transported in armored motor vehicles, or by messenger, but not including any other risks of transportation or navigation; also insurance against loss or damage to such an insured's premises or to his furnishings, fixtures, equipment, safes, and vaults therein, caused by burglary, robbery, theft, vandalism or malicious mischief, or any attempt thereat.

Laws 1957, p. 241, § 708.

§36-709. "Title insurance" defined.

"Title insurance" is insurance of owners of property or others having an interest therein, or liens or encumbrances thereon, against loss by encumbrance, or defective titles, or invalidity, or adverse claim to title.

Laws 1957, p. 242, § 709.

§36-710. Limit of risk.

A. No insurer shall retain any risk on any one subject of insurance, whether located or to be performed in Oklahoma or elsewhere, in an amount exceeding ten percent (10%) of its surplus to policyholders.

B. A "subject of insurance" for the purposes of this section, as to insurance against fire and hazards other than windstorm or earthquake, includes all properties insured by the same insurer which are customarily considered by underwriters to be subject to loss or damage from the same fire or other such hazard insured against.

C. Reinsurance authorized by Section 711 of this article shall be deducted in determining risk retained. As to surety risks, deduction shall also be made of the amount assumed by any established incorporated cosurety and the value of any security deposited, pledged, or held subject to the surety's consent and for the surety's protection.

D. "Surplus to policyholders" for the purpose of this section shall be deemed to include any voluntary reserves which are not required pursuant to law, and shall be determined from the last sworn statement of the insurer on file with the Insurance Commissioner or by the last report of examination by the Insurance Commissioner, whichever is the more recent at time of assumption of such risk.

E. As to alien insurers, other than life insurers domiciled in Canada, this section shall relate only to risks and surplus to policyholders of the insurer's United States branch.

F. This section shall not apply to group life or group or blanket accident and health insurance, title insurance, insurance of ocean marine risks or marine protection and indemnity risks, workers' compensation insurance, employers' liability coverages, nor to any policy or type of coverage as to which the maximum possible loss to the insurer is not readily ascertainable on issuance of the policy. Added by Laws 1957, p. 242, § 710, operative July 1, 1957.

§36-711. Allowance for credit or increase in amount at risk - Contract requirements.

A. 1. No credit shall be allowed, as an admitted asset or as a deduction from liability, to any ceding insurer for reinsurance nor

increase the amount it is authorized to have at risk unless the reinsurance contract provides, in substance, that in the event of the insolvency of the ceding insurer, the reinsurance shall be payable under a contract or contracts reinsured by the assuming insurer on the basis of reported claims allowed by the liquidation court, without diminution because of the insolvency of the ceding insurer. Such payments shall be made directly to the ceding insurer or to its domiciliary liquidator, except:

- a. if the contract or other written agreement specifically provides another payee of such reinsurance in the event of the insolvency of the ceding insurer, or
- b. if the assuming insurer, with the consent of the direct insureds, has assumed such policy obligations of the ceding insurer as direct obligations of the assuming insurer to the payees under such policies and in substitution for the obligations of the ceding insurer to such payees.

2. The reinsurance agreement may provide that the domiciliary liquidator of an insolvent ceding insurer shall give written notice to the assuming insurer of the pendency of a claim against such ceding insurer on the contract reinsured within a reasonable time after such claim is filed in the liquidation proceeding. During the pendency of such claim, any assuming insurer may investigate such claim and interpose, at its own expense, in the proceeding where such claim is to be adjudicated, any defenses which it deems available to the ceding insurer, or its liquidator. Such expense may be filed as a claim against the insolvent ceding insurer to the extent of a proportionate share of the benefit which may accrue to the ceding insurer solely as a result of the defense undertaken by the assuming insurer. If two or more assuming insurers are involved in the same claim and a majority in interest elect to interpose one or more defenses to such claim, the expense shall be apportioned in accordance with the terms of the reinsurance agreement as though such expense had been incurred by the ceding insurer.

B. This section shall not apply to insurance of ocean marine risks or marine protection and indemnity risks.
Added by Laws 1957, p. 242, § 711. Amended by Laws 1984, c. 149, § 4, eff. Nov. 1, 1984; Laws 1993, c. 79, § 3, eff. Sept. 1, 1993; Laws 2000, c. 169, § 5, eff. Nov. 1, 2000.

§36-712. Posting of standard policies and endorsements.

Any insurance company offering property and casualty insurance policies may, in lieu of mailing or delivering, post on their website standard policies and endorsements that do not contain personally identifiable information. If an insurer elects to provide standard policy and endorsement forms on the insurer's

website, the insurer shall ensure that the policies and endorsements are posted in a manner that complies with the following conditions:

1. The policy and endorsements shall be easily accessible;
 2. The insurer shall archive all policies and endorsements for a period of five (5) years after the expiration of the policy;
 3. All policies and endorsements shall be posted in a manner that allows an insured to print and save electronic copies of the documents;
 4. The insurer shall provide notice at the time of issuance of the initial policy forms and upon renewal of a method by which the insured may obtain, without charge, a paper or electronic copy of the insured's policy and endorsements;
 5. Each declaration page issued to an insured shall clearly identify the policy and endorsement forms purchased by the insured; and
 6. The insurer shall provide notice of any changes to the forms or endorsements and of the insured's right to obtain, without charge, paper or electronic copies of the forms in the manner the insurer customarily communicates with the insured.
- Added by Laws 2013, c. 68, § 1, eff. Nov. 1, 2013.

§36-900.1. Short title.

Sections 11 through 36 of this act shall be known and may be cited as the "Oklahoma Insurance Rating Act".
Added by Laws 1987, c. 210, § 11, eff. July 1, 1987.

§36-901. Repealed by Laws 2006, c. 264, § 82, eff. July 1, 2006.

§36-901.1. Purposes of act.

- A. The purposes of this act are:
 1. To promote the public welfare by regulating insurance rates to the end that they shall not be excessive, inadequate or unfairly discriminatory;
 2. To improve availability, fairness and reliability of insurance and insurance rates;
 3. To authorize essential cooperative action among insurers in the ratemaking process and to regulate such activity to prevent practices that tend to substantially lessen competition or to create a monopoly;
 4. To encourage the most efficient and economic marketing practices; and
 5. To encourage the providing of price and other information to enable consumers to purchase insurance suitable for their needs and to foster competitive insurance markets.
 - B. This act shall be liberally construed to effectuate its purposes.
- Added by Laws 1987, c. 210, § 13, eff. July 1, 1987.

§36-901.2. Definitions.

As used in this act unless the context otherwise requires:

1. "Act" means the Oklahoma Insurance Rating Act;
2. "Commissioner" means the Insurance Commissioner of the State of Oklahoma or his designee;
3. "Department" means the Insurance Department of the State of Oklahoma;
4. "Rate" means the cost of insurance per exposure unit, whether expressed as a single number or as a prospective loss cost and an adjustment to account for the treatment of expenses, profit and variations in loss experience, prior to any application of individual risk variations based on loss or expense considerations, and does not include minimum premiums:
 - a. "prospective loss cost", as used in this paragraph, means that portion of a rate that does not include provisions for expenses, other than loss adjustment expenses, or profit, and are based on historical aggregate losses and loss adjustment expenses adjusted through development to their ultimate value and projected through trending to a future point in time, and
 - b. "expenses", as used in this paragraph, means that portion of a rate attributable to acquisition, field supervision, collection expenses, general expenses, taxes, licenses, and fees; and
5. "Rating organization, advisory organization or statistical organization" means any two or more insurers acting in cooperation or in concert for the purpose of making rates, rating plans or rating systems.

Added by Laws 1987, c. 210, § 14, eff. July 1, 1987. Amended by Laws 1994, c. 129, § 2, eff. Sept. 1, 1994; Laws 2006, c. 264, § 11, eff. July 1, 2006.

§36-901.3. Filing - Contents and procedure.

A. In order to be complete, a filing shall contain the following:

1. A memorandum briefly summarizing the gist of the filing;
2. An index to the filing;
3. A clear and concise statement of the action desired to be taken by the Commissioner;
4. References to the sections of law and to rules and regulations which authorize the action desired to be taken by the Insurance Commissioner or which support the information contained in the filing;
5. An explanation of the application of the filing factors, which are contained in subsection A of Section 902.2 or subsection B

of Section 985 of this title, together with assumptions and conclusions concerning such factors;

6. References to exhibits and other documents contained in the filing which are relied upon to support the action requested by the filing; and

7. Any other information required by the Commissioner.

B. If the filer is an advisory organization or joint underwriting association, it is sufficient for such information to be provided in summary form for all the filer's members and subscribers.

C. If a filing is incomplete, the Commissioner shall notify the filer, in writing, of the necessary materials required by this article, by rules of the Commissioner or by orders adopted by the Commissioner to complete the filing.

Added by Laws 1987, c. 210, § 15, eff. July 1, 1987. Amended by Laws 1997, c. 418, § 31, eff. Nov. 1, 1997; Laws 2006, c. 264, § 12, eff. July 1, 2006.

§36-901.4. Hearings - Period of advisement - Additional information, analysis, consideration and investigation.

A. Not less than ten (10) days in advance of a meeting to determine whether a hearing will be held, the Insurance Commissioner shall give notice to each insurer or organization making the filing, to each party to the filing and to any person who annually requests in writing to be notified of filings made pursuant to this act, of the date, time and location of any hearing or rehearing, the name of the insurer or organization making the filing and of the parties to the filing and a brief statement of the action requested in the filing.

B. Hearings shall be open to the public.

C. Any person aggrieved with respect to a rate filing may make written application to the Commissioner to participate in any hearing called by the Commissioner. If the Commissioner finds the application to be supported by reasonable grounds, it may allow the applicant to appear in person or by counsel.

At the conclusion of any formal hearing and before the final closing of such hearing, any party in interest upon timely request shall be granted, as a matter of right, a continuance of twenty-four (24) hours for the purpose of making examination and analyses of documents introduced in the hearing.

D. The evidentiary procedures of the Administrative Procedures Act shall apply to hearings conducted pursuant to this act.

E. Upon written request seasonably made by a person affected by the hearing, and at such person's expense, the Commissioner shall cause a full stenographic record of the proceedings to be made by a competent court reporter. If transcribed, such record shall be a part of the Commissioner's record of the hearing, and a copy of such

stenographic record shall be furnished to any other party having a direct interest therein at the request and expense of such party.

F. Following a hearing on a filing made pursuant to this act, the Commissioner may take the matter under advisement for up to thirty (30) calendar days, subject to the provisions of Section 903 of this title.

G. At any time during the pendency of a filing, the Commissioner may:

1. Require the submission of additional information by any party to the filing;

2. Solicit proposals for independent analysis of the filing by qualified technicians, such technicians to be chosen pursuant to the provisions of Section 332 of this title;

3. Consider the findings of its employees or the technician; and

4. Conduct other or additional investigations including additional hearings.

Added by Laws 1987, c. 210, § 16, eff. July 1, 1987. Amended by Laws 1991, c. 204, § 8, eff. Sept. 1, 1991; Laws 2006, c. 264, § 13, eff. July 1, 2006.

§36-901.5. Filing of advisory prospective loss costs and supporting actuarial data and statistical data for workers' compensation insurance.

A. Rating organizations shall develop and file for approval with the Insurance Commissioner in accordance with the provisions of this section, a filing containing advisory prospective loss costs and supporting actuarial and statistical data for workers' compensation insurance. Each insurer shall individually file their own specific profit and expense factors used to determine the final rates it will file for approval and the effective date of any rate changes.

B. As used in this section:

1. "Expenses" means that portion of a rate attributable to acquisition, field supervision, collection expenses, general expenses, taxes, licenses and fees;

2. "Rate" means the cost of insurance per exposure unit, whether expressed as a single number or as a prospective loss cost with an adjustment to account for the treatment of expenses, profit and variations in loss experience, prior to any application of individual risk variations based on loss or expense considerations, and does not include minimum premiums; and

3. "Prospective loss costs" means that portion of a rate that does not include provision for expenses (other than loss adjustment expenses) or profit, and is based on historical aggregate losses and loss adjustment expenses adjusted through development to its

ultimate value and projected through trending to a future point in time.

Added by Laws 1993, c. 349, § 22, eff. Sept. 1, 1993. Amended by Laws 1997, c. 418, § 32, eff. Nov. 1, 1997.

§36-902. Excessive, inadequate or unfairly discriminatory rates.

A. The Insurance Commissioner shall not approve rates for insurance which are excessive, inadequate, or unfairly discriminatory.

1. An excessive rate is one which:
 - a. is unreasonably high for the insurance provided, or
 - b. is unreasonable because (1) a reasonable degree of competition does not exist in the area with respect to the classification to which such rate is applicable and (2) the rate is unreasonably high for the insurance provided.
2. An inadequate rate is one which:
 - a. is (1) unreasonably low for the insurance provided and (2) the continued use of such rate endangers, or if continued would endanger, the solvency of the insurer, or
 - b. is (1) unreasonably low for the insurance provided and (2) the continued use of such rate by the insurer has, or if continued would have, the effect of destroying competition or creating a monopoly, or
 - c. is insufficient to cover projected losses, expenses and a reasonable margin for profit for the line of insurance coverage to be offered in this state by the filer.
3. A rate shall not be unfairly discriminatory.
 - a. A rate is not unfairly discriminatory because it is based in part upon the establishment or modification of classifications of risks based upon:
 - (1) the size of the risk,
 - (2) the expense or difficulty in management of the risk,
 - (3) the individual experience of the risk,
 - (4) the location or dispersion of the risk, or
 - (5) any other reasonable consideration attributable to the risk.
 - b. A rate is not unfairly discriminatory in relation to another in the same class of business if it reflects equitably the differences in expected losses and expenses. Rates are not unfairly discriminatory because different premiums result for policyholders with like loss exposures but different expense factors, or with like expense factors but different

loss exposures, if the rates reflect the differences with reasonable accuracy.

- c. A rate shall be deemed unfairly discriminatory as to a risk or group of risks if the application of premium discounts, credits, or surcharges among such risks does not bear a reasonable relationship to the expected loss and expense experience among the various risks.
- d. A rate shall never be based upon race, color, creed or national origin.

B. The systems of expense provisions included in the rates for use by any insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the requirements of the operating methods of any such insurer or group with respect to any kind of insurance or subdivision or combination thereof for which subdivision or combination separate expense provisions are applicable.

C. Nothing in this act shall be construed to require uniformity in insurance rates, classifications, rating plans, or practices.

D. Nothing in this act shall abridge or restrict the freedom of contract of insurers, agents, brokers or employees with reference to the commissions, compensation, or salaries to be paid to such agents, brokers, or employees by insurers.

Added by Laws 1957, p. 243, § 902, operative July 1, 1957. Amended by Laws 1980, c. 322, § 33, eff. Jan. 1, 1981; Laws 1986, c. 251, § 9, eff. Nov. 1, 1986; Laws 1987, c. 210, § 17, eff. July 1, 1987; Laws 1988, c. 291, § 2, eff. Nov. 1, 1988; Laws 2006, c. 264, § 14, eff. July 1, 2006; Laws 2024, c. 195, § 1, eff. Nov. 1, 2024.

§36-902.1. Repealed by Laws 2005, 1st Ex.Sess., c. 1, § 33, eff. July 1, 2005.

§36-902.2. Factors for review of filing - Weight - Prohibited expenses.

A. The Insurance Commissioner when reviewing a filing shall give due consideration to the following when, in its discretion, it determines that such factor or factors are applicable:

1. Past loss experience within and outside this state;
2. Prospective loss experience within and outside this state;
3. Physical hazards insured;
4. Safety and loss prevention programs;
5. Underwriting practices and judgment;
6. Catastrophe hazards;
7. Reasonable underwriting profit and contingencies;
8. Dividends, savings or unabsorbed premium deposits allowed or returned to policyholders;
9. Past expenses within and outside this state;

10. Prospective expenses within and outside this state;
 11. Existence of classification rates for a given risk;
 12. Investment income within and outside this state;
 13. Rarity or peculiarity of the risks within and outside this state;
 14. In the case of workers' compensation rates, differences in the hazard levels of different geographical regions of the state;
 15. All other relevant factors within and outside this state;
- and
16. Whether existing rates continue to meet the standards of this article.

B. The Commissioner shall determine the weight to be accorded each of the factors contained in subsection A of this section.

C. Past or prospective expenses within or outside this state pursuant to paragraphs 9 and 10 of subsection A of this section shall not include prohibited expenses for advertising or prohibited expenses for membership in organizations.

For the purpose of this subsection:

1. "Prohibited expenses for advertising" means the cost of advertising in any media the purpose of which is to influence legislation or to advocate support for or opposition to a candidate for public office;
2. "Prohibited expenses for advertising" shall not mean:
 - a. any communication to customers and the public of information regarding an insurer's insurance products,
 - b. any communication to customers and the public of safety, safety education or loss prevention information,
 - c. periodic publications or reports to stockholders or members required by the certificate or bylaws of the insurer,
 - d. any communication with customers and the public which provides instruction in the use of the insurer's products and services, or
 - e. any communication with customers and the public for giving notice or information required by law or otherwise necessary;
3. "Prohibited expenses for membership" means the cost of membership in any organization which conducts substantial efforts, including but not limited to prohibited expenses for advertising, the purpose of which is to influence legislation or to advocate support for or opposition to a candidate for public office; and
4. "Prohibited expenses for membership" shall not mean the cost of membership in advisory organizations or other organizations the primary purpose of which is to provide statistical information on losses.

Added by Laws 1987, c. 210, § 18, eff. July 1, 1987. Amended by Laws 1993, c. 349, § 23, eff. Sept. 1, 1993; Laws 1994, c. 129, § 3, eff. Sept. 1, 1994; Laws 1997, c. 418, § 34, eff. Nov. 1, 1997; Laws 2004, c. 519, § 6, eff. Nov. 1, 2004; Laws 2006, c. 264, § 15, eff. July 1, 2006.

§36-902.3. Calculation of workers' compensation premiums - Equalization of expected losses and expenses between high and low wage-paying employers - Agency rule report.

A. Workers' compensation premiums shall be calculated on a basis that, as nearly as is practicable, after the effects of experience rating and other applicable rating plans have been considered, the sum of expected losses and expected expenses as a percentage of premium shall be the same for high- and low-wage-paying employers in the same job classification.

B. The Insurance Commissioner and the Board of Directors of CompSource Mutual Insurance Company shall:

1. Determine the extent to which high-wage-paying employers are paying premiums higher than those which would produce the same ratio of expected losses and expenses to premiums as for employers paying lower wages;

2. Determine whether this effect is primarily seen in certain types of job classifications;

3. Investigate alternatives and modifications to the current method of computing workers' compensation premiums, including wage rate recognition plans used in other states, split classifications, wage rate caps, and hours worked;

4. Conduct a hearing or hearings on this matter, including consideration of other alternatives; and

5. Adopt rules by January 1, 1996, to become effective on July 1, 1996, unless disapproved by the Legislature, to equalize, as nearly as is practicable, expected losses and expenses as a percentage of workers' compensation premiums for high- and low-wage-paying employers in the same job classification. If the effect is found to be primarily seen in certain types of job classifications, the rules shall be adopted to apply only to such types of job classifications. The adopted rules shall be subject to legislative review and shall be promulgated as permanent rules pursuant to the Administrative Procedures Act. The agency rule report required by the Administrative Procedures Act shall include a rule impact statement together with an actuarial analysis of the proposed rule describing in detail the classes of persons who most likely will be affected by the proposed rules; the classes of persons who will benefit from the adopted rules; and the probable economic impact of the proposed rules upon the affected classes of persons. The actuarial analysis shall be prepared by an independent actuary who is a member of the Casualty Actuarial Society or the American

Academy of Actuaries who is qualified as described in the U.S. Qualifications Standards promulgated by the American Academy of Actuaries pursuant to the Code of Professional Conduct to perform such actuarial analysis selected by the Insurance Commissioner. The rules shall not be invalidated on the ground that the contents of the rule impact statement or the actuarial analysis are insufficient or inaccurate.

C. The cost of the premium adjustment plan shall be allocated among all employers purchasing workers' compensation insurance from all carriers.

Added by Laws 1994, 2nd Ex. Sess., c. 1, § 3, emerg. eff. Nov. 4, 1994. Amended by Laws 2006, c. 264, § 16, eff. July 1, 2006; Laws 2013, c. 254, § 15, eff. Jan. 1, 2015.

§36-902.4. Repealed by Laws 2006, c. 264, § 82, eff. July 1, 2006.

§36-903. Repealed by Laws 2006, c. 264, § 82, eff. July 1, 2006.

§36-903.1. Repealed by Laws 1997, c. 418, § 125, eff. Nov. 1, 1997.

§36-903.2. Workplace safety plans - Expenses of implementation.

No insurance company shall request and the Insurance Commissioner shall not approve an increase for the expense portion of insurance company rate filings based upon the requirements of Section 6701 of this title.

Added by Laws 1994, 2nd Ex. Sess., c. 1, § 15, emerg. eff. Nov. 4, 1994. Amended by Laws 2006, c. 264, § 17, eff. July 1, 2006; Laws 2013, c. 254, § 16; Laws 2015, c. 298, § 6, eff. Nov. 1, 2015.

§36-904. Inspection of filed rates - Information to insured - Proceedings by aggrieved persons - False or misleading information - Withholding policy or evidence.

A. All schedules and insurance rates and supporting information filed in accordance with the provisions of this article shall be open to inspection to the public after such filings are made.

B. Every advisory organization and every insurer which makes its own rates shall, within a reasonable time after receiving written request therefor and upon payment of such reasonable charge as it may make, furnish to any insured affected by a rate made by it, or to the authorized representative of such insured, all pertinent information as to such rate.

C. Every advisory organization and every insurer which makes its own rates shall provide within the state reasonable means whereby any person, aggrieved by the application of its rating system, may be heard, in person or by his authorized representative, on his written request to revise the manner in which such rating system has been applied in connection with the insurance afforded

him. If the advisory organization or insurer fails to grant or reject such request, within thirty (30) days after it is made, this applicant may proceed in the same manner as if his application had been rejected. Any party affected by the action of such advisory organization or such insurer on such request may, within thirty (30) days after written notice of such action, appeal to the Insurance Commissioner, which, after a hearing held upon not less than ten (10) days written notice to the appellant and to such advisory organization or insurer, may modify, affirm or reverse such action.

D. No insurer, agent, broker, or advisory organization may willfully withhold required information from or give false or misleading information to the Commissioner.

E. No insurer, agent, or broker shall fail to furnish to an insured any policy or comparable evidence of insurance to which the insured is entitled.

Added by Laws 1957, p. 245, § 904, operative July 1, 1957. Amended by Laws 1987, c. 210, § 20, eff. July 1, 1987; Laws 2006, c. 264, § 18, eff. July 1, 2006.

§36-905. Repealed by Laws 2006, c. 264, § 82, eff. July 1, 2006.

§36-906. Repealed by Laws 1987, c. 210, § 38, eff. July 1, 1987.

§36-907. Repealed by Laws 2024, c. 345, § 18, eff. Nov. 1, 2024.

§36-907.1. Monitoring and examination of rates.

A. The Insurance Commissioner shall monitor and examine the adequacy of rates of any insurer and advisory organization in this state. In so doing, the Commissioner shall:

1. Utilize existing relevant information, analytical systems and other sources; or
2. Cause or participate in the development of new relevant information, analytical systems and other sources.

B. The Commissioner may require the maintenance and submission of records, memoranda or information relating to rates from such insurers and advisory organizations. The Commissioner or any authorized representative of the Commissioner may examine any such record, memoranda or information concerning rates. The application for the acceptance of any license or permit issued pursuant to the provision of this title shall be deemed consent for the inspection and examination of such records, memoranda or information.

C. The Commissioner shall conduct such monitoring and examination required pursuant to this section within the Insurance Department, at the place of business of such insurers and advisory organizations, in cooperation with other state insurance departments, through outside contractors or in any other appropriate manner.

D. The cost of such examination and monitoring shall be assessed against insurers and advisory organizations on an equitable and practical basis established, after hearing, in a rule promulgated by the Commissioner.

E. The monitoring and examinations required pursuant to the provisions of this section, shall be conducted in a reasonably economical manner.

Added by Laws 1985, c. 236, § 4, emerg. eff. July 8, 1985. Amended by Laws 1987, c. 210, § 23, eff. July 1, 1987; Laws 2006, c. 264, § 20, eff. July 1, 2006; Laws 2009, c. 432, § 8, eff. July 1, 2009.

§36-908. Administrative penalties.

The Insurance Commissioner may, if the Commissioner finds that any person or organization has violated the provisions of any statute, rule, or order for which the Commissioner has jurisdiction, impose a penalty of not more than Five Thousand Dollars (\$5,000.00) for each such violation. Such penalties may be in addition to any other penalty provided by law.

No penalty shall be imposed except upon a written order of the Commissioner or the appointed independent hearing examiner, stating the findings of the Commissioner or the appointed independent hearing examiner after notice and opportunity for a hearing in accordance with Article II of the Administrative Procedures Act.

Added by Laws 1957, p. 247, § 908, operative July 1, 1957. Amended by Laws 1983, c. 68, § 8, eff. Nov. 1, 1983; Laws 1987, c. 210, § 24, eff. July 1, 1987; Laws 1997, c. 418, § 36, eff. Nov. 1, 1997; Laws 2006, c. 264, § 21, eff. July 1, 2006; Laws 2024, c. 195, § 2, eff. Nov. 1, 2024.

This section was purportedly repealed by Laws 2024, c. 345, § 19 but without reference to Laws 2024, c. 195, § 2, which amended it.

§36-924.1. Automobile or motorcycle accident prevention course for certain individuals - Reduction of premium charges.

A. Any schedule of rates or rating plan for automobile or motorcycle liability and physical damage insurance submitted to or filed with the Insurance Commissioner shall provide for an appropriate reduction in premium charges for those insured persons for a three-year period after successfully completing a motor vehicle accident prevention course which shall include but not be limited to an automobile or motorcycle accident prevention course as approved by the insurance company of the policyholder. Provided, there shall be no reduction in premiums for a course attended pursuant to a court order in connection with a motor vehicle violation or an alcohol- or drug-related offense.

B. All insurance companies writing automobile or motorcycle liability and physical damage insurance in this state shall allow an

appropriate reduction in premium charges to all eligible persons pursuant to this section.

C. Upon successfully completing the approved course, each participant shall be issued by the sponsoring agency of the course, a certificate which shall be the basis of qualification for the discount on insurance.

D. Each participant shall successfully complete an approved course each three (3) years to continue to be eligible for the discount on insurance.

E. An approved course pursuant to this section shall provide at least six (6) hours of instruction.

Added by Laws 1985, c. 122, § 1, eff. Jan. 1, 1986. Amended by Laws 1990, c. 297, § 1, eff. Sept. 1, 1990; Laws 1991, c. 204, § 11, eff. Sept. 1, 1991; Laws 1995, c. 138, § 1, eff. Nov. 1, 1995; Laws 2002, c. 49, § 1, eff. Nov. 1, 2002; Laws 2004, c. 519, § 8, eff. Nov. 1, 2004; Laws 2007, c. 326, § 1, eff. Nov. 1, 2007; Laws 2024, c. 345, § 13, eff. Nov. 1, 2024.

§36-924.2. Rating plans for workers' compensation self-insureds - Reduced premium charges for successful participation in occupational safety and health programs - Qualification - Certificate - Records.

A. Any rate, schedule of rates or rating plan for workers' compensation insurance submitted to or filed with the Insurance Commissioner, or fixed by the Board of Directors of CompSource Mutual Insurance Company, and premiums, by whatever name, for workers' compensation for self-insureds except for group self-insured associations shall provide for an appropriate reduction in premium charges, by whatever name, for those eligible insured employers who have successfully participated in the occupational safety and health consultation, education and training program administered by the Commissioner of the Department of Labor pursuant to Section 414 of Title 40 of the Oklahoma Statutes.

B. All insurance companies writing workers' compensation insurance in this state and all self-insureds providing workers' compensation insurance except for group self-insured associations, shall allow an appropriate reduction in premium charges to all eligible employers who qualify for the reduction pursuant to the provisions of this section.

C. Eligible employers shall be those employers:

1. Who are insured by an insurance company writing workers' compensation insurance in this state; or

2. Who are self-insured.

D. In order to qualify for the reduction in workers' compensation insurance premium, an employer shall successfully participate annually in the occupational safety and health consultation, education and training program administered by the Department of Labor. Successful participation shall be defined as:

1. Undergoing a safety and health hazard survey of the workplace, including an evaluation of the employer's safety and health program and onsite interviews with employees by the Department's consultant;

2. Correcting all hazards identified during the onsite visit within a reasonable period of time as established by the Department;

3. Establishing an effective workplace safety and health program and implementing program provisions within a reasonable period of time as established by the Department. The program shall include:

- a. demonstration of management commitment to worker safety and health,
- b. procedures for identifying and controlling workplace hazards,
- c. development and communication of safety plans, rules and work procedures, and
- d. training for supervisors and employees in safe and healthful work practices;

4. Reducing by one-third (1/3) or more the extent to which the lost workday case rate, as measured by the Department of Labor, was above the national average for the industry at the time the employer elected to participate in the occupational safety and health consultation, education and training program, or maintaining a rate at or below the national average for the industry; and

5. Documenting a reduction in workers' compensation claims for the preceding year by showing one of the following:

- a. a ten percent (10%) reduction in the dollar amount of claims,
- b. a ten percent (10%) reduction in the severity of claims, or
- c. no reported claims,

as a result of attending the occupational safety and health consultation, education and training program administered by the Department of Labor.

E. 1. Upon successful participation in the occupational safety and health consultation, education and training program as defined in subsection D of this section, an employer shall be issued a certificate by the Commissioner of the Department of Labor which shall be the basis of qualification for the reduction in workers' compensation insurance premium, by whatever name. The certificate shall qualify the employer for a premium reduction for a one-year period.

2. Upon issuance of a certificate to an employer, the Commissioner of the Department of Labor shall mail a copy of the certificate to the employer's insurer. Any insurer required by this section to allow an appropriate reduction in premium charges to a qualified employer which willfully fails to allow such reduction

after receiving a copy of the certificate shall be subject, after notice and hearing, to an administrative fine, imposed by the Insurance Commissioner, which shall be not less than Ten Thousand Dollars (\$10,000.00) or three times the amount of the premium reduction, whichever is greater. The Insurance Commissioner shall promulgate rules necessary to carry out the provisions of this paragraph.

F. The Insurance Commissioner and the Administrator of the Workers' Compensation Court shall maintain records documenting reductions in workers' compensation insurance premiums granted pursuant to this section and shall make an annual report of such reductions to the President Pro Tempore of the Senate and the Speaker of the House of Representatives by May 1 of each year. Insurers shall report such premium reductions in their annual statement.

Added by Laws 1988, c. 317, § 1, eff. Nov. 1, 1988. Amended by Laws 1990, c. 2, § 1, eff. Sept. 1, 1990; Laws 1993, c. 349, § 24, eff. Sept. 1, 1993; Laws 1994, c. 129, § 5, eff. Sept. 1, 1994; Laws 2002, c. 50, § 1, eff. Nov. 1, 2002; Laws 2006, c. 264, § 22, eff. July 1, 2006; Laws 2013, c. 254, § 17, eff. Jan. 1, 2015.

§36-924.3. Appeals of rating classifications.

The Insurance Commissioner shall adopt rules and regulations creating a procedure for an employer to appeal its rating classification for workers' compensation insurance to the Commissioner. Any hearings pursuant to this procedure shall be subject to the Administrative Procedures Act.

Added by Laws 1990, c. 283, § 21, eff. Sept. 1, 1990. Amended by Laws 2006, c. 264, § 23, eff. July 1, 2006.

§36-924.4. Repealed by Laws 2015, c. 298, § 29, eff. Nov. 1, 2015.

§36-924.5. Repealed by Laws 2015, c. 298, § 29, eff. Nov. 1, 2015.

§36-928. Repealed by Laws 2006, c. 264, § 82, eff. July 1, 2006.

§36-929. Repealed by Laws 2006, c. 264, § 82, eff. July 1, 2006.

§36-930. Repealed by Laws 2006, c. 264, § 82, eff. July 1, 2006.

§36-931. Repealed by Laws 2006, c. 264, § 82, eff. July 1, 2006.

§36-932. Joint underwriting or joint reinsurance.

A. Every group, association or other organization of insurers which engages in joint underwriting or joint reinsurance, shall be subject to regulation with respect thereto, as herein provided, subject, with respect to joint underwriting, to all other provisions

of this act, and with respect to joint reinsurance as provided in this act.

B. If, after a hearing, the Insurance Commissioner finds that any activity or practice of any such group, association or other organization, is unfair or unreasonable, or otherwise inconsistent with the provisions of this act, the Commissioner may issue a written order specifying in what respects such act or practice is unfair or unreasonable or otherwise inconsistent with the provisions of this act, and require the discontinuance, within a reasonable time under the circumstances, of such act or practice.

Added by Laws 1980, c. 322, § 26, eff. Jan. 1, 1981. Amended by Laws 1987, c. 210, § 29, eff. July 1, 1987; Laws 2006, c. 264, § 24, eff. July 1, 2006.

§36-933. Repealed by Laws 2006, c. 264, § 82, eff. July 1, 2006.

§36-934. Repealed by Laws 2006, c. 264, § 82, eff. July 1, 2006.

§36-935. Repealed by Laws 2006, c. 264, § 82, eff. July 1, 2006.

§36-936. Repealed by Laws 2006, c. 264, § 82, eff. July 1, 2006.

§36-937. Hearing on order or decision by Commission made without a hearing - Appeal to Supreme Court.

A. Any insurer or advisory organization aggrieved by any order or decision of the Insurance Commissioner, made without a hearing, may, within thirty (30) days after notice of the order to the insurer or organization, make written request to the Commissioner for a hearing thereon. The Commissioner shall hear such party or parties within twenty (20) days after receipt of such request and shall give not less than ten (10) days' written notice of the time and place of the hearing. Within fifteen (15) days after such hearing, the Commissioner shall affirm, reverse or modify the previous action of the Commissioner, specifying its reasons therefor. Pending such hearing and decision thereon, the Commissioner may suspend or postpone the effective date of the previous action of the Commissioner.

B. Nothing contained in this act shall require the observance at any hearing, of formal rules of pleading or evidence.

C. Except as otherwise provided in this act, any order or decision of the Commissioner made pursuant to this act shall be subject to review by appeal to the Supreme Court of Oklahoma at the instance of any party in interest. Such party in interest may appeal from such order or decision by filing with the Clerk of the Supreme Court, within thirty (30) days from the date of such order or decision, a petition in error with a copy of the order or decision appealed from. The time limit prescribed herein for filing

the petition in error may not be extended. The Supreme Court shall prescribe, by rule, the manner in which the record of the proceedings, sought to be reviewed, shall be perfected and the time for its completion. The appeal shall not stay the execution of any order or decision of the Commissioner unless the Supreme Court shall, for cause shown, order that said decision or order be stayed pending such appeal, in which event the Court shall determine the terms and conditions upon which the same shall be stayed; provided, premiums collected prior to the effective date of the order of the Court imposing a stay shall be retained by the insurer unless the Court finds that such premiums were obtained by fraud, or unless otherwise ordered by the Court.

The Court may, in disposing of the issue before it, determine all issues of law and fact, and may modify, affirm or reverse the order or decisions of the Commissioner in whole or in part. Added by Laws 1980, c. 322, § 31, eff. Jan. 1, 1981. Amended by Laws 1988, c. 28, § 1, eff. Nov. 1, 1988; Laws 2006, c. 264, § 25, eff. July 1, 2006.

§36-940. Inquiry regarding making claim - Prohibited acts.

No insurer that issues any type of property or casualty insurance policy in this state shall increase premium rates, cancel a policy, or refuse to issue or renew a policy solely on the basis of a policyholder inquiring about making a claim, if the policyholder does not in fact submit a claim.

Added by Laws 2004, c. 32, § 1, eff. Nov. 1, 2004.

§36-941. Certain cancellation, refusal to renew or increase of premium rate for motor vehicle liability or collision insurance policies prohibited - Exemptions.

A. No insurance carrier who issues motor vehicle insurance policies in this state shall assign driving record points, cancel, refuse to issue or renew, or charge a higher premium rate for any motor vehicle liability or collision insurance policy for the reason that the insured has been involved in a motor vehicle collision and was not at fault.

B. No insurance carrier who issues motor vehicle insurance policies in this state shall cancel, refuse to issue or renew, or charge a higher premium for any motor vehicle liability or collision insurance policy for the reason that the insured had lower liability limits with a previous insurer without actuarial justification. This prohibition includes using prior limits for company or tier placement unless the insurer provides actuarial justification.

C. This section shall not apply to an insured who has been convicted of:

1. Homicide or assault arising out of the operation of any motor vehicle; or

2. A violation of Section 11-902 or 761 of Title 47 of the Oklahoma Statutes as being impaired by or under the influence of alcohol or intoxicating liquor or who was under the influence of any substance included in the Uniform Controlled Dangerous Substances Act.

Added by Laws 1980, c. 99, § 1, eff. Oct. 1, 1980. Amended by Laws 1984, c. 254, § 4, eff. Nov. 1, 1984; Laws 1988, c. 27, § 1, eff. Nov. 1, 1988. Renumbered from § 7-508 of Title 47 by Laws 1988, c. 27, § 4, eff. Nov. 1, 1988. Amended by Laws 2001, c. 363, § 10, eff. July 1, 2001; Laws 2004, c. 519, § 10, eff. Nov. 1, 2004; Laws 2005, c. 1, § 38, emerg. eff. March 15, 2005.

NOTE: Laws 2004, c. 96, § 1 repealed by Laws 2005, c. 1, § 39, emerg. eff. March 15, 2005.

§36-941.2. Motor vehicle liability policies - Provision relating to financial responsibility limits of another state or province.

Every motor vehicle liability insurance policy approved by the Insurance Commissioner shall include a provision providing that the financial responsibility limits of another state or province shall be met if so required by the other state and if the financial responsibility limits of the other state or province are higher than those required by the state where the motor vehicle is principally garaged. The policy does not have to contain the exact wording of this section or any other exact wording. Language which is substantially similar to this section shall be considered to be in compliance with this section.

Added by Laws 2004, c. 96, § 2, eff. Nov. 1, 2004.

§36-942. Motor vehicle liability or collision policies - Traffic record as basis of determination - Penalties.

Any insurance carrier that issues motor vehicle liability or collision insurance policies in this state shall not establish or apply premium rates, increase premium rates, cancel a policy, or refuse to issue or renew a policy, based on any traffic record maintained by the Department of Public Safety which covers a period of time more than three (3) years prior to the date the insurance carrier makes a determination to take any such action; provided however, those offenses that are provided for in subsection C of Section 941 of this title and the offense of reckless driving as provided for in Section 11-901 of Title 47 of the Oklahoma Statutes may be considered by an insurance carrier for a period of not more than five (5) years.

Added by Laws 1988, c. 27, § 2, eff. Nov. 1, 1988. Amended by Laws 2004, c. 519, § 11, eff. Nov. 1, 2004; Laws 2006, c. 322, § 3, eff. July 1, 2006.

§36-943. Motor vehicle policies - Insurers prohibited from canceling, increasing premium rates or refusing to issue or renew policy based on traffic charges under certain circumstances.

A. No insurance carrier who issues motor vehicle policies in this state shall use traffic complaints, traffic citations or other legal forms of traffic charges as a basis for cancellation of a motor vehicle insurance policy, increasing premium rates for a motor vehicle insurance policy or refusing to issue or renew a motor vehicle insurance policy, where:

1. the insured was acquitted of the charge;
2. the insured was arrested and no charges were filed; or
3. the insured was arrested and the charges were dismissed.

B. The Insurance Commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance business in this state of any insurance carrier violating the provisions of this section or may censure the insurer or impose a fine.

Added by Laws 1990, c. 81, § 1, eff. Sept. 1, 1990.

§36-944. Motor vehicle policies - Restriction on cancellation or increasing rates.

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

Added by Laws 1974, c. 3, § 2, operative March 4, 1974. Amended by Laws 1987, c. 25, § 2, emerg. eff. April 15, 1987. Renumbered from § 11-801b of Title 47 by Laws 2002, c. 397, § 35, eff. Nov. 1, 2002. Amended by Laws 2005, c. 129, § 6, eff. Nov. 1, 2005.

§36-950. Short title.

This act shall be known and may be cited as the "Use of Credit Information in Personal Insurance Act".

Added by Laws 2003, c. 127, § 1, eff. Nov. 1, 2003.

§36-951. Application of act.

This act shall apply to personal insurance and not to commercial insurance. This act shall apply to personal insurance policies either written to be effective or renewed on or after nine (9) months following the effective date of this act.

Added by Laws 2003, c. 127, § 2, eff. Nov. 1, 2003.

§36-952. Definitions.

As used in this act:

1. "Adverse action" means a denial or cancellation of, an increase in any charge for, or a reduction or other adverse or unfavorable change in the terms of coverage or amount of, any insurance, existing or applied for, in connection with the underwriting of personal insurance;

2. "Affiliate" means any company that controls, is controlled by, or is under common control with another company;

3. "Applicant" means an individual who has applied to be covered by a personal insurance policy with an insurer;

4. "Consumer" means an insured whose credit information is used or whose insurance score is calculated in the underwriting or rating of a personal insurance policy or an applicant for such a policy;

5. "Consumer reporting agency" means any person which, for monetary fees, dues, or on a cooperative nonprofit basis, regularly engages in whole or in part in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer reports to third parties;

6. "Credit information" means any credit-related information derived from a credit report, found on a credit report itself, or provided on an application for personal insurance. Information that is not credit-related shall not be considered "credit information", regardless of whether it is contained in a credit report or in an application, or is used to calculate an insurance score;

7. "Credit report" means any written, oral, or other communication of information by a consumer reporting agency bearing on a consumer's credit worthiness, credit standing or credit capacity which is used or expected to be used or collected in whole or in part for the purpose of serving as a factor to determine personal insurance premiums, eligibility for coverage, or tier placement;

8. "Insurance score" means a number or rating that is derived from an algorithm, computer application, model, or other process that is based in whole or in part on credit information for the purposes of predicting the future insurance loss exposure of an individual applicant or insured; and

9. "Personal insurance" means private passenger automobile, homeowners, motorcycle, mobile-homeowners and noncommercial dwelling fire insurance policies and boat, personal watercraft, snowmobile and recreational vehicle policies. Such policies must be individually underwritten for personal, family or household use. No other type of insurance shall be included as personal insurance for the purpose of this act.

Added by Laws 2003, c. 127, § 3, eff. Nov. 1, 2003.

§36-953. Use of credit information - Prohibited acts.

An insurer authorized to do business in this state that uses credit information to underwrite or rate risks, shall not:

1. Use an insurance score that is calculated using income, gender, address, zip code, ethnic group, religion, marital status, or nationality of the consumer as a factor;

2. Deny, cancel or fail to renew a policy of personal insurance solely on the basis of credit information, without consideration of any other applicable underwriting factor independent of credit information and not expressly prohibited by paragraph 1 of this section;

3. Base renewal rates for personal insurance of an insured solely upon credit information, without consideration of any other applicable factor independent of credit information;

4. Take adverse action against a consumer solely because the consumer does not have a credit card account, without consideration of any other applicable factor independent of credit information;

5. Consider an absence of credit information or an inability to calculate an insurance score in underwriting or rating personal insurance, unless the insurer does one of the following:

- a. treats the consumer as otherwise approved by the Insurance Commissioner, if the insurer presents information that an absence or inability relates to the risk for the insurer,
- b. treats the consumer as if the applicant or insured had neutral credit information, as defined by the insurer, or
- c. excludes the use of credit information as a factor and use only other underwriting criteria;

6. Take an adverse action against a consumer based on credit information, unless an insurer obtains and uses a credit report issued or an insurance score calculated within ninety (90) days from the date the policy is first written or renewal is issued;

7. Use credit information unless not later than every thirty-six (36) months following the last time that the insurer obtained current credit information for the insured, the insurer recalculates the insurance score or obtains an updated credit report. Regardless of the requirements of this subsection:

- a. at annual renewal, upon the request of a consumer or the agent of the consumer, the insurer shall reunderwrite and rerate the policy based upon a current credit report or insurance score. An insurer need not recalculate the insurance score or obtain the updated credit report of a consumer more frequently than once in a twelve-month period,
- b. the insurer shall have the discretion to obtain current credit information upon any renewal before the

thirty-six (36) months, if consistent with its underwriting guidelines, and

- c. no insurer need obtain current credit information for an insured, despite the requirements of paragraph 7 of this section, if one of the following applies:
 - (1) the insurer is treating the consumer as otherwise approved by the Commissioner,
 - (2) the insured is in the most favorably priced tier of the insurer, within a group of affiliated insurers. However, the insurer shall have the discretion to order a report, if consistent with its underwriting guidelines,
 - (3) credit was not used for underwriting or rating the insured when the policy was initially written. However, the insurer shall have the discretion to use credit for underwriting or rating the insured upon renewal, if consistent with its underwriting guidelines, or
 - (4) the insurer reevaluates the insured beginning no later than thirty-six (36) months after inception and thereafter based upon other underwriting or rating factors, excluding credit information; and

8. Use the following as a negative factor in any insurance scoring methodology or in reviewing credit information for the purpose of underwriting or rating a policy of personal insurance:

- a. credit inquiries not initiated by the consumer or inquiries requested by the consumer for the credit information of the consumer,
- b. inquiries relating to insurance coverage, if so identified on a credit report of the consumer,
- c. collection accounts with a medical industry code, if so identified on the credit report of the consumer,
- d. multiple lender inquiries, if coded by the consumer reporting agency on the credit report of the consumer as being from the home mortgage industry and made within thirty (30) days of one another, unless only one inquiry is considered, and
- e. multiple lender inquiries, if coded by the consumer reporting agency on the credit report of the consumer as being from the automobile lending industry and made within thirty (30) days of one another, unless only one inquiry is considered.

Added by Laws 2003, c. 127, § 4, eff. Nov. 1, 2003. Amended by Laws 2010, c. 222, § 8, eff. Nov. 1, 2010.

§36-953.1. Exceptions by insurers to certain events influencing credit information - Request by insured or applicant.

A. Notwithstanding any other law or regulation, an insurer that uses credit information shall, upon written request from an applicant for insurance coverage or an insured upon a form provided by the Insurance Commissioner, provide reasonable exceptions to the rate of the insurer, rating classifications, company or tier placement or underwriting rules or guidelines for a consumer who has experienced and whose credit information has been directly influenced by any of the following events:

1. Catastrophic event declared by the federal or state government;
2. Serious illness or injury, or serious illness or injury to an immediate family member;
3. Death of an immediate family member;
4. Divorce or involuntary interruption of legally owed alimony or support payments;
5. Identity theft;
6. Temporary loss of employment for a period of three (3) months or more, if it results from involuntary termination;
7. Military deployment overseas; and
8. Other events, as determined by the Insurance Commissioner.

B. If an applicant or insured submits a request for an exception as provided in subsection A of this section, an insurer may, in its sole discretion:

1. Require the consumer to provide reasonable written and independently verifiable documentation of the event;
2. Require the consumer to demonstrate that the event had direct and meaningful impact on the credit information of the consumer;
3. Require the request be made no more than sixty (60) days from the date of the application for insurance or the policy renewal;
4. Grant an exception despite the consumer not providing the initial request for an exception in writing; or
5. Grant an exception to requiring a written request where the consumer asks for a consideration of repeated events or the insurer has considered this event previously.

C. An insurer is in compliance with any other provision of law or Insurance Department rule relating to underwriting, rating or rate filing notwithstanding the granting an exception under this section. Nothing in this section shall be construed to provide a consumer or other insured with a cause of action that does not exist in the absence of this section.

D. The insurer shall provide notice to consumers, either at the time of acceptance of an insurance application or at policy renewal, that reasonable exceptions are available and information about how the consumer may inquire further.

Added by Laws 2021, c. 478, § 3, emerg. eff. May 12, 2021.

§36-954. Reunderwriting and rerating of insured - Refund of overpayment.

If it is determined through the dispute resolution process set forth in the federal Fair Credit Reporting Act, 15 USC 1681i(a)(5), that the credit information of a current insured was incorrect or incomplete and if the insurer receives notice of such determination from either the consumer reporting agency or from the insured, the insurer shall reunderwrite and rerate the consumer within thirty (30) days of receiving the notice. After reunderwriting or rerating the insured, the insurer shall make any adjustments necessary, consistent with its underwriting and rating guidelines. If an insurer determines that the insured has overpaid premium, the insurer shall refund to the insured the amount of overpayment calculated back to the shorter of either the last twelve (12) months of coverage or the actual policy period.

Added by Laws 2003, c. 127, § 5, eff. Nov. 1, 2003.

§36-955. Disclosure statement.

A. If an insurer writing personal insurance uses credit information in underwriting or rating a consumer, the insurer or its agent shall disclose, either on the insurance application or at the time the insurance application is taken, that it may obtain credit information in connection with such application. Such disclosure shall be either written or provided to an applicant in the same medium as the application for insurance. The insurer need not provide the disclosure statement required under this section to any insured on a renewal policy, if such consumer has previously been provided a disclosure statement.

B. Use of the following example disclosure statement constitutes compliance with this section: "In connection with this application for insurance, we may review your credit report or obtain or use a credit-based insurance score based on the information contained in that credit report. We may use a third party in connection with the development of your insurance score".

Added by Laws 2003, c. 127, § 6, eff. Nov. 1, 2003.

§36-956. Adverse action based upon credit information - Notification to consumer.

If an insurer takes an adverse action based upon credit information, the insurer shall:

1. Provide notification to the consumer that an adverse action has been taken, in accordance with the requirements of the federal Fair Credit Reporting Act, 15 USC 1681m(a); and

2. Provide notification to the consumer explaining the reason for the adverse action. The reasons must be provided in sufficiently clear and specific language so that a person can

identify the basis for the insurer's decision to take an adverse action. Such notification shall include a description of up to four factors that were the primary influences of the adverse action. The use of generalized terms such as "poor credit history", "poor credit rating", or "poor insurance score" does not meet the explanation requirements of this subsection. Standardized credit explanations provided by consumer reporting agencies or other third-party vendors are deemed to comply with this section.

Added by Laws 2003, c. 127, § 7, eff. Nov. 1, 2003.

§36-957. Filing of scoring models or other scoring processes.

A. Insurers that use insurance scores to underwrite and rate risks must file their scoring models or other scoring processes with the Insurance Department. A third party may file scoring models on behalf of insurers. A filing that includes insurance scoring may include loss experience justifying the use of credit information.

B. Any filing relating to credit information is considered trade secret under Section 85 et seq. of Title 78 of the Oklahoma Statutes.

Added by Laws 2003, c. 127, § 8, eff. Nov. 1, 2003.

§36-958. Indemnification of agents.

An insurer shall indemnify, defend, and hold agents harmless from and against all liability, fees, and costs arising out of or relating to the actions, errors, or omissions of an agent who obtains or uses credit information or insurance scores for an insurer, provided the agent follows the instructions of or procedures established by the insurer and complies with any applicable law or regulation. Nothing in this section shall be construed to provide a consumer or other insured with a cause of action that does not exist in the absence of this section.

Added by Laws 2003, c. 127, § 9, eff. Nov. 1, 2003.

§36-959. Sale of data or lists by consumer reporting agencies.

A. No consumer reporting agency shall provide or sell data or lists that include any information that in whole or in part was submitted in conjunction with an insurance inquiry about a consumer's credit information or a request for a credit report or insurance score. Such information includes, but is not limited to, the expiration dates of an insurance policy or any other information that may identify time periods during which a consumer's insurance may expire and the terms and conditions of the consumer's insurance coverage.

B. The restrictions provided in subsection A of this section do not apply to data or lists the consumer reporting agency supplies to the insurance agent from whom information was received, the insurer

on whose behalf such agent acted, or such insurer's affiliates or holding companies.

C. Nothing in this section shall be construed to restrict any insurer from being able to obtain a claims history report or a motor vehicle report.

Added by Laws 2003, c. 127, § 10, eff. Nov. 1, 2003.

§36-961. Premium discount or rate reduction for resistance to tornado or other wind events.

A. Commencing on April 1, 2018, insurance companies shall provide a premium discount or insurance rate reduction in an amount and manner as established in subsection D of this section and pursuant to Section 3 of this act only when the company determines that the premium discount or rate reduction is actuarially justified and there is sufficient and credible evidence of cost savings, which can be attributed to the construction standards set forth in subsection B of this section. A premium discount or rate reduction shall be available under the terms specified in this section to any owner who builds or locates a new insurable property in the State of Oklahoma to resist loss due to tornado or other catastrophic windstorm events. Insurance companies shall be required to offer such a premium discount or rate reduction only when the insurer determines they are actuarially justified and there is sufficient and credible evidence of cost savings, which can be attributed to the construction standards set forth in subsection B of this section. In addition, insurance companies may also offer additional adjustments in deductible, other risk differentials, or a combination thereof, collectively referred to as other adjustments.

B. To obtain the premium discount, rate reduction, or other adjustment provided in this section, an insurable property located in this state shall be certified as constructed in accordance with Appendix Y of the 2015 Oklahoma Uniform Building Code, as amended, including all tornado mitigation construction requirements, as long as its standards are equal to or greater than the FORTIFIED Home High Wind and Hail Standards as certified by the Institute for Business and Home Safety (IBHS), or the FORTIFIED Home High Wind and Hail Standards as may from time to time be adopted by the Institute for Business and Home Safety or successor entity. An insurable property shall be certified as conforming to the applicable building code only after an inspection of the insurable property has been satisfactorily completed by a certified or licensed building inspector and certified to be conforming to the applicable building code including all high wind and hail mitigation construction requirements. An insurable property shall be certified as conforming to the FORTIFIED Home High Wind and Hail Standards only after evaluation and certification by an evaluator certified pursuant to the FORTIFIED Home High Wind and Hail Standards.

C. An owner of insurable property claiming a premium discount, rate reduction, or other adjustment pursuant to this section shall maintain sufficient certification records and construction records including, but not limited to, a certification of compliance with the applicable building code or the FORTIFIED Home High Wind and Hail Standards provided in subsection B of this section, receipts from contractors, receipts for materials and records from local building officials. The records shall be subject to audit by the Insurance Commissioner, or his or her representatives, and copies of any such records shall be presented to the insurer or potential insurer of a property owner before the premium discount, rate reduction, or other adjustment becomes effective for the insurable property.

D. Insurers that write policies that are subject to the premium discount or rate reduction in this section and that are required to submit rates and rating plans to the Commissioner pursuant to Section 987 of Title 36 of the Oklahoma Statutes shall submit a rating plan certified by their actuary as actuarially justified providing for the premium discount or rate reduction described in this section. An insurer is not required to provide the same amount of premium discount, rate reduction, or other adjustment for a building code insurable property as the insurer would to an insurable property conforming to the FORTIFIED Home High Wind and Hail Standards. A premium discount, rate reduction, or other adjustment shall only apply to policies that provide wind or hail coverage and to that portion of the premium for wind or hail coverage. A premium discount, rate reduction, or other adjustment shall apply exclusively to the wind and hail premium applicable to improved insurable property. If an insurer already offers an actuarially justified hail resistance discount, that hail-related discount shall be deemed as having met the requirements of this act as it pertains to hail-related discounts or rate reductions and no additional hail-related discount or rate reduction shall be required. If an insurer already offers an actuarially justified discount for IBHS FORTIFIED Home standards, that discount shall be deemed as having met the requirements of this act as it pertains to wind-related discounts or rate reductions and no additional wind-related discount or rate reduction shall be required. Insurers shall apply any applicable premium discount, rate reduction or other adjustment to the wind and hail premium at the policy renewal that follows the submission of the certification to the insurer. At the time of a policy renewal for which a premium discount, rate reduction, or other adjustment has previously been made, the insurer may request documentation or recertification that the fortified standards as described in subsection C of this section continue to be met. In addition to the requirements of this section, an insurer

may voluntarily offer any other mitigation adjustment that the insurer deems appropriate.

Added by Laws 2017, c. 349, § 1, eff. Nov. 1, 2017.

§36-962. Premium discount or rate reduction for resistance to tornado or other wind events for retrofit properties.

A. Commencing on April 1, 2018, insurance companies shall provide a premium discount or insurance rate reduction in an amount and manner as established in subsection D of this section and pursuant to Section 3 of this act only when the company determines that the premium discount or rate reduction is actuarially justified and there is sufficient and credible evidence of cost savings, which can be attributed to the construction standards set forth in subsection B of this section. A premium discount or rate reduction shall be available under the terms specified in this section to any owner who retrofits his or her insurable property located in the State of Oklahoma to resist loss due to tornado or other catastrophic windstorm events. Insurance companies shall be required to offer a premium discount or rate reduction only when the insurer has deemed the adjustments to be actuarially justified and there is sufficient and credible evidence of cost savings, which can be attributed to the construction standards set forth in subsection B of this section. In addition, insurance companies may also offer additional adjustments in deductible, other risk differentials, or a combination thereof, collectively referred to as other adjustments.

B. To obtain the premium discount, rate reduction, or other adjustment provided in this section, an insurable property shall be retrofitted to the FORTIFIED Home High Wind and Hail Standards, as may from time to time be adopted by the Institute for Business and Home Safety (IBHS). Wind-Zone-3-HUD-Code manufactured homes installed on a permanent foundation and retrofitted as defined in the FORTIFIED Home High Wind and Hail Standards, as may from time to time be adopted by the Institute for Business and Home Safety, shall be eligible for the premium discount or rate reduction provided in this section. An insurable property shall be certified as conforming to FORTIFIED Home High Wind and Hail Standards only after evaluation and certification by an evaluator certified pursuant to the FORTIFIED Home High Wind and Hail Standards.

C. An owner of insurable property claiming a premium discount, rate reduction, or other adjustment pursuant to this section shall maintain sufficient certification records and construction records including, but not limited to, a certification of compliance with the FORTIFIED Home High Wind and Hail Standards as provided in subsection B of this section, receipts from contractors, and receipts for materials. The records shall be subject to audit by the Insurance Commissioner, or his or her representatives, and copies of any such records shall be presented to the insurer or

potential insurer of a property owner before the premium discount, rate reduction, or other adjustment becomes effective for the insurable property.

D. Insurers that write policies that are subject to the premium discount or rate reduction in this section and that are required to submit rates and rating plans to the Commissioner pursuant to Section 987 of Title 36 of the Oklahoma Statutes shall submit rating plans certified by their actuary as actuarially justified providing for the premium discounts or rate reductions described in this section. A premium discount, rate reduction, or other adjustment shall only apply to policies that provide wind or hail coverage and to that portion of the premium for wind or hail coverage. A premium discount, rate reduction, or other adjustment shall apply exclusively to the wind and hail premium applicable to improved insurable property. If an insurer already offers an actuarially justified hail resistance discount, that hail-related discount shall be deemed as having met the requirements of this act as it pertains to hail-related discounts or rate reductions and no additional hail-related discount or rate reduction shall be required. If an insurer already offers an actuarially justified discount for IBHS FORTIFIED Home standards, that discount shall be deemed as having met the requirements of this act as it pertains to wind-related discounts or rate reductions and no additional wind-related discount or rate reduction shall be required. Insurers shall apply the premium discount, rate reduction, or other adjustment to the wind premium at the policy renewal that follows the submission of the certification to the insurer. At the time of a policy renewal for which a premium discount, rate reduction, or other adjustment has previously been made, the insurer may request documentation or recertification that the fortified standards as described in subsection C of this section continue to be met. In addition to the requirements of this section, an insurer may voluntarily offer any other mitigation adjustment that the insurer deems appropriate.

Added by Laws 2017, c. 349, § 2, eff. Nov. 1, 2017.

§36-963. Insurable property defined.

For the purposes of this act, the term "insurable property" includes single-family residential property. Insurable property also includes modular homes satisfying the codes, standards or techniques as provided in Section 1 or 2 of this act. Manufactured homes or mobile homes are excluded, except as expressly provided in subsection B of Section 2 of this act.

Added by Laws 2017, c. 349, § 3, eff. Nov. 1, 2017.

§36-964. Applicability date.

This act shall only apply to new insurance policies written, or existing policies renewed, on or after April 1, 2018.

Added by Laws 2017, c. 349, § 4, eff. Nov. 1, 2017.

§36-965. Promulgation of rules to implement and administer the act.

The Insurance Commissioner shall promulgate such rules as are necessary to implement and administer this act; however, the Commissioner shall not suggest, set or otherwise impose any standard discount amount, target or benchmark under this act.

Added by Laws 2017, c. 349, § 5, eff. Nov. 1, 2017.

§36-971. Short title – Strengthen Oklahoma Homes Act.

This act shall be known and may be cited as the "Strengthen Oklahoma Homes Act".

Added by Laws 2024, c. 293, § 1, eff. Nov. 1, 2024.

§36-972. Strengthen Oklahoma Homes (SOH) Program.

A. There is hereby established within the Department of Insurance the Strengthen Oklahoma Homes (SOH) Program, to continue until November 1, 2027.

B. This act does not create an entitlement for property owners or obligate the state in any way to fund the inspection, construction, or retrofitting of residential property in this state. Implementation of the SOH Program is subject to the receipt of federal grants or funds or from other sources of grants or funds. The Department shall use its best efforts to obtain grants or funds from the federal government or other funding sources to supplement the financial resources of the SOH Program that may be provided by the state.

C. The SOH Program shall apply for financial grants to construct or retrofit insurable property as defined in Section 963 of Title 36 of the Oklahoma Statutes to resist loss due to a tornado or other catastrophic windstorm events or hail as prescribed in subsection B of Section 962 of Title 36 of the Oklahoma Statutes.

D. The SOH Program may also make grants or funding available to nonprofit entities for projects to construct or retrofit insurable properties to resist loss due to tornado or other catastrophic windstorm events or hail if such grants or funding to nonprofit entities are allowable under grant or funding rules, requirements, guidelines, or criteria. However, a nonprofit entity shall agree to administer the grants or funds as the SOH Program would be required to administer grants or funds, and the entity shall provide documentation to the Department in a timely manner as requested by the Department.

E. All mitigation shall be based upon the securing of all required local permits and applicable inspections in keeping with local building codes and the Insurance Institute for Business and Home Safety (IBHS) Fortified Homes Program. Mitigation projects are subject to random reinspection of all projects.

F. The Insurance Commissioner may promulgate rules and eligibility requirements necessary for the proper administration of this act and pursuant to any instructions or requirements on grants or funds received by the Department for the SOH Program. Added by Laws 2024, c. 293, § 2, eff. Nov. 1, 2024.

§36-973. Grant eligibility – Applications – Fund use.

A. To be eligible for a grant, residential property owners applying for a grant must be able to meet the eligibility requirements as set forth by the Insurance Department for each grant type. These requirements shall include, but not be limited to, the following:

1. The residential property owner shall have or be constructing insurable property, as defined in Section 963 of Title 36 of the Oklahoma Statutes, that has been granted a homestead exemption, or, if new build, provides other documentation approved by the Insurance Commissioner;

2. The residential property owner shall claim their primary residence in a county where grants are being approved;

3. The home to be mitigated shall be an owner-occupied, single-family, primary residence and cannot be a condominium or mobile home;

4. The home shall be in good repair unless damaged by a tornado or other catastrophic windstorm event or hail. SOH Program grant funds cannot be used for maintenance or repairs but may be used in conjunction with repairs or reconstruction necessitated by damages from a tornado or other catastrophic windstorm event or hail;

5. A Certified IBHS Evaluator shall prequalify the insurable property as mitigable and identify all improvements required to achieve IBHS FORTIFIED Roof™ (Roof), FORTIFIED Silver™ (Silver), FORTIFIED Gold™ (Gold), or successor designation, or similar standard approved by the Insurance Commissioner. The residential property owner shall select the evaluator from a list provided by the SOH Program and shall pay the evaluator's fee;

6. The residential property owner shall obtain bids from at least three IBHS Certified Contractors approved by the SOH Program;

7. The residential property owner shall construct or retrofit the home to the Insurance IBHS Roof or Silver, Gold, or successor designation or similar standard approved by the Commissioner, which shall include the hail supplement;

8. The residential property owner shall provide proof of an in-force policy providing wind insurance on the home; and

9. If the insurable property is in a special flood hazard area, the residential property owner shall provide proof of an in-force flood insurance policy. The flood policy may be from the National Flood Insurance Program (NFIP) or a private carrier.

B. Grant applications shall be filed electronically with the Department in the form and manner prescribed by the Commissioner, along with any applicable transaction fees.

C. Documents, materials, and other information submitted to the Department by property owners or insurance companies in support of a grant application shall be confidential by law and privileged, shall not be subject to open records requests, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.

D. Grants to residential property owners shall be used to construct or retrofit an insurable property as defined in Section 963 of Title 36 of the Oklahoma Statutes to resist loss due to a tornado or other catastrophic windstorm event or hail as prescribed in subsection B of Section 962 of Title 36 of the Oklahoma Statutes.

E. Retrofit projects within six (6) months of the date the residential property owner receives notice of the grant approval. New builds shall be completed within the timeframe approved by the Commissioner. Failure to complete the project timely may result in forfeiture of the grant.

F. Grant funds shall only be paid once a certificate has been issued for the fortified standard approved by the Commissioner. Grant funds shall be paid by the Department or another designated agency, on behalf of the residential property owner, directly to the contractor who performed the mitigation work.

G. Applications will be accepted on a first-come, first-served basis within each income tier established by the Commissioner, with priority given to lower-income applicants, applicants who live in locations that, based on historical data, have a higher susceptibility to catastrophic weather events, and applicants meeting any other criteria the Commissioner determines is appropriate to meet the purpose of the program.

H. Any entity providing funds to the SOH Program shall be permitted to establish additional rules and guidelines under which those funds may be used, as long as such rules and guidelines do not violate any state or federal law.

I. The Department may conduct random inspections of funds, records, and/or properties to detect any fraud.

Added by Laws 2024, c. 293, § 3, eff. Nov. 1, 2024.

§36-974. IBHS certified contractor required.

A. Under the Strengthen Oklahoma Homes (SOH) Program, a residential property owner shall hire an IBHS certified contractor who is capable of performing work that satisfies the standards prescribed by this act and the rules adopted thereto.

B. The Insurance Department shall not endorse or otherwise provide preferential treatment to any contractor.

C. A residential property owner is responsible for any amount owed to a contractor that exceeds awarded grant monies.

D. To be eligible to work on a project funded by the SOH Program as a contractor, a contractor shall meet all program requirements, including, but not limited to, those listed in this subsection, and maintain a current copy of all applicable certificates, licenses, and proof of insurance coverages with the program office:

1. If required under Oklahoma law, the contractor shall hold a valid and active contractor's license or registration in Oklahoma and be free from all disciplinary action by the applicable licensing board;

2. If applicable, the contractor shall be registered to do business in Oklahoma with the Secretary of State;

3. The contractor shall have an in-force general liability policy with Five Hundred Thousand Dollars (\$500,000.00) in liability coverage;

4. The contractor shall have workers' compensation and employer's liability insurance in accordance with and to the extent required by Oklahoma law;

5. The contractor shall hold an active IBHS FORTIFIED Roof™ Contractor Certification or FORTIFIED Professional Certification. The contractor is responsible for paying all fees associated with certification and training;

6. The contractor must successfully register as a supplier or payee with the Office of Management and Enterprise Services;

7. The contractor shall maintain accurate contact information with the SOH Program;

8. The contractor shall agree to follow the SOH Program's procedures and rules as prescribed by the Insurance Commissioner;

9. The contractor shall not have a financial interest in any project funded by the SOH Program for which they perform work other than receiving payment on behalf of the homeowner from the SOH Program and shall report to the SOH Program any potential conflicts of interest before work commences; and

10. The contractor shall not be the evaluator for any project funded by the SOH Program.

Added by Laws 2024, c. 293, § 4, eff. Nov. 1, 2024.

§36-975. Evaluator requirements.

To be eligible to work on a project funded by the Strengthen Oklahoma Homes (SOH) Program as an evaluator, the evaluator shall meet all program requirements, including, but not limited to, those listed in this section, and maintain a current copy of all applicable certificates and licenses with the SOH Program office:

1. The evaluator must be in good standing with IBHS and maintain an active IBHS certification as a FORTIFIED Home Evaluator.

The evaluator is responsible for paying all fees associated with certification and training;

2. If applicable, the evaluator shall be registered to do business in Oklahoma with the Secretary of State;

3. The evaluator shall agree to follow the SOH Program's procedures and rules as prescribed by the Commissioner;

4. The evaluator shall maintain accurate contact information with the SOH Program;

5. The evaluator shall not have any financial interest in any project which they inspect for designation purposes for the SOH Program;

6. The evaluator shall not be a contractor or supplier of any materials or products or systems installed in any home they inspect for designation purposes for the SOH Program;

7. The evaluator shall not be the sales agent for any home being designated for the SOH Program; and

8. The evaluator shall inform the SOH Program of any potential conflicts of interest.

Added by Laws 2024, c. 293, § 5, eff. Nov. 1, 2024.

§36-976. Strengthen Oklahoma Homes Revolving Fund.

A. There is hereby created in the State Treasury a revolving fund for the Insurance Department, to be designated the "Strengthen Oklahoma Homes Revolving Fund". The fund shall be a continuing fund, not subject to fiscal year limitations, and shall consist of any monies deposited to the fund from the receipt of federal grants or funds or from other sources of grants or funds. All monies accruing to the credit of the fund are hereby appropriated and may be budgeted and expended by the Department for the purpose of assisting the Strengthen Oklahoma Homes (SOH) Program in performing all acts that relate to the function and purpose of the SOH Program. Warrants for expenditures from the revolving fund shall be drawn by the State Treasurer, based on claims signed by an authorized employee or employees of the Insurance Department, and filed with the Director of the Office of Management and Enterprise Services.

B. Monies collected pursuant to this act shall be deposited in the Strengthen Oklahoma Homes Revolving Fund. Monies shall not lapse, unless otherwise specified under federal funding or federal grant, or a grant or funds from another source, or be transferred to the State Insurance Commissioner Revolving Fund or other state funds and shall not be redistributed.

C. Notwithstanding any other provision of law, the Insurance Commissioner may transfer from the State Insurance Commissioner Revolving Fund to the Strengthen Oklahoma Homes Revolving Fund up to fifty percent (50%), but in an amount not to exceed Ten Million Dollars (\$10,000,000.00), of the balance remaining in the State

Insurance Commissioner Revolving Fund at the end of each fiscal year beginning with the fiscal year ending on June 30, 2024.
Added by Laws 2024, c. 293, § 6, eff. Nov. 1, 2024.

§36-981. Short title and purposes of act.

Short Title and Purposes of Act.

A. Sections 981 through 998 of this title and Sections 22, 23 and 24 of this act shall constitute a part of the Oklahoma Insurance Code and shall be known and may be cited as the "Property and Casualty Competitive Loss Cost Rating Act".

B. The purposes of the Property and Casualty Competitive Loss Cost Rating Act are:

1. To promote price competition among insurers so as to provide rates that are responsive to competitive market conditions;
2. To protect policyholders and the public against the adverse effects of excessive, inadequate or unfairly discriminatory rates;
3. To prohibit unlawful price-fixing agreements and other anticompetitive behavior by insurers;
4. To provide regulatory procedures for the maintenance of appropriate data reporting systems;
5. To provide regulatory controls in the absence of a competitive marketplace; and
6. To authorize essential cooperative action among insurers in the ratemaking process and to regulate such activity to prevent practices that substantially lessen competition or create a monopoly.

Added by Laws 1999, c. 83, § 1, eff. Nov. 1, 1999. Amended by Laws 2004, c. 591, § 12, eff. Nov. 1, 2004.

§36-982. Definitions.

Definitions.

As used in the Property and Casualty Competitive Loss Cost Rating Act:

1. "Accepted actuarial standards" means the standards adopted by the Casualty Actuarial Society Statement of Principles regarding property and casualty ratemaking or the Standards of Practice adopted by the Actuarial Standards Board;
2. "Advisory organization" means any corporation, unincorporated association, partnership or person, whether located inside or outside this state, that is licensed in accordance with Section 1140 of this title and which assists insurers in ratemaking-related activities such as enumerated in Section 1142 of this title;
3. "Classification system" or "classification" means the process of grouping risks with similar risk characteristics so that differences in costs may be recognized;
4. "Commercial risk" means any kind of risk that is not a personal risk;

5. "Commissioner" means the Commissioner of Insurance of this state;

6. "Competitive market" means a market which has not been found to be noncompetitive pursuant to Section 984 of this title;

7. "Developed losses" means losses, including loss adjustment expenses, adjusted using accepted actuarial standards, to eliminate the effect of differences between current payment or reserve estimates and those which are anticipated to provide actual ultimate loss, including loss adjustment expense payments;

8. "Expenses" means that portion of a rate attributable to acquisition, field supervision, collection expenses, general expenses, taxes, licenses and fees;

9. "Experience rating" means a rating procedure utilizing past insurance experience of the individual policyholder to forecast future losses by measuring the policyholder's loss experience against the loss experience of policyholders in the same classification to produce a prospective premium credit, debit or unity modification;

10. "Joint underwriting" means a voluntary arrangement established to provide insurance coverage for a risk pursuant to which two or more insurers jointly contract with the insured at a price and under policy terms agreed upon between the insurers;

11. "Loss adjustment expense" means the expenses incurred by the insurer in the course of settling claims;

12. "Market" means the statewide interaction between buyers and sellers of identical or readily substitutable products that provide insurance protection of identifiable perils to buyers;

13. "Mass marketed plan" means a method of selling property-liability insurance wherein the insurance is offered to employees of particular employers or to members of particular associations or organizations or to persons grouped in other ways, and the employer or association or other organization has agreed to, or otherwise affiliated itself with, the sale of such insurance to its employees or members;

14. "Noncompetitive market" means a market for which there is a ruling in effect pursuant to Section 984 of this title that a reasonable degree of competition does not exist;

15. "Personal risk" means homeowners, tenants, private passenger nonfleet automobiles, manufactured homes and other property and casualty insurance for personal, family or household needs, including any property and casualty insurance that is otherwise intended for noncommercial coverage;

16. "Pool" means a voluntary arrangement, established on an ongoing basis, pursuant to which two or more insurers participate in the sharing of risks on a predetermined basis. The pool may operate through an association, syndicate or other pooling agreement;

17. "Prospective loss costs" means historical aggregate losses and may include loss adjustment expenses, including all assessments that are loss based, projected through development to their ultimate value and through trending to a future point in time;

18. "Pure premium rate" means that portion of the rate which represents the loss costs per unit of exposure including loss adjustment expense;

19. "Rate" or "rates" means that cost of insurance per exposure unit whether expressed as a single number or as a prospective loss cost with an adjustment to account for the treatment of expenses, profit, and individual insurer variation in loss experience, prior to any application of individual risk variations based on loss or expense considerations, and does not include minimum premium;

20. "Residual market mechanism" means an arrangement, either voluntary or mandated by law, involving participation by insurers in the equitable apportionment among them of insurance which may be afforded applicants who are unable to obtain insurance through ordinary methods;

21. "Special assessments" means guaranty fund assessments, Special Indemnity Fund assessments, Vocational Rehabilitation Fund assessments, and other similar assessments. Special assessments shall not be considered as either expenses or losses;

22. "Statistical plan" means the plan, system or arrangement used in collecting data;

23. "Supplementary rating information" means any manual or plan of rates, classification, rating schedule, minimum premium, policy fee rating rule and any other information needed to determine the applicable premium in effect or to be in effect. This includes, rating plans, territory codes and descriptions and rules which include factors or relativities such as increased limits factors, deductible discounts or relativities, classification relativities or similar factors used to determine the rate in effect or to be in effect;

24. "Supporting information" means the experience and judgment of the filer and the experience or data of other insurers or advisory organizations relied upon by the filer, the interpretation of any other data relied upon by the filer, descriptions of methods used in making the rates and any other information required by the Commissioner to be filed; and

25. "Trending" means any procedure for projecting losses to the average date of loss, or premiums or exposures to the average date of writing, for the period during which the policies are to be effective.

Added by Laws 1999, c. 83, § 2, eff. Nov. 1, 1999. Amended by Laws 2004, c. 519, § 13, eff. Nov. 1, 2004; Laws 2007, c. 125, § 1, eff. July 1, 2007.

§36-983. Scope of act.

The Property and Casualty Competitive Loss Cost Rating Act applies to all forms of property and casualty insurance written in this state by insurers licensed in this state. The Property and Casualty Competitive Loss Cost Rating Act shall not apply to:

1. Reinsurance;
2. Life insurance;
3. Accident and health insurance;
4. Insurance of vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks commonly insured under marine, excluding inland marine, insurance as determined by the Commissioner; and
5. Title insurance.

Added by Laws 1999, c. 83, § 3, eff. Nov. 1, 1999. Amended by Laws 2004, c. 519, § 14, eff. Nov. 1, 2004; Laws 2005, 1st Ex.Sess., c. 1, § 3, eff. July 1, 2005.

§36-984. Competitive market.

Competitive Market.

A. A competitive market is presumed to exist for a line of insurance unless the Commissioner, after a hearing, issues an order stating that a reasonable degree of competition does not exist in the market. The burden of proof in any hearing shall be placed on the party or parties advocating the position that competition does not exist. Any ruling that a market is not competitive shall identify the factors causing the market not to be competitive. Such order shall expire no later than one (1) year after issue unless rescinded earlier by the Commissioner or unless the Commissioner renews the rule after a hearing and a finding as to the continued lack of a reasonable degree of competition. Any ruling that renews the finding that competition does not exist shall also identify the factors that cause the market to continue not to be competitive.

B. 1. In determining whether a reasonable degree of competition exists within a line of insurance, the Commissioner shall consider the following factors:

- a. the number of insurers actively engaged in writing coverage,
- b. market shares of the leading writers and the changes in market shares over a reasonable period of time,
- c. existence of financial or economic barriers that could prevent new firms from entering the market,
- d. measures of market concentration and changes of market concentration over time,
- e. whether long-term profitability for insurers in the market is reasonable in relation to industries of comparable business risk, and

f. the relationship of insurers' costs to revenue over a reasonable period of time.

2. All determinations by the Commissioner shall be made on the basis of findings of fact and conclusions of law.

3. The ruling may be challenged in the district court.

C. The Commissioner shall monitor the degree and continued existence of competition in this state on an ongoing basis. In doing so, the Commissioner may utilize existing relevant information, analytical systems and other sources, or rely on some combination thereof. Such activities may be conducted internally within the Insurance Department, in cooperation with other state insurance departments, through outside contractors or in any other appropriate manner.

Added by Laws 1999, c. 83, § 4, eff. Nov. 1, 1999. Amended by Laws 2004, c. 519, § 15, eff. Nov. 1, 2004.

§36-985. Ratemaking standards.

Ratemaking Standards.

A. A rate may not be excessive, inadequate or unfairly discriminatory.

1. No rate in a competitive market may be determined to be excessive. A rate in a noncompetitive market may be determined to be excessive if it is likely to produce a profit that is unreasonably high for the insurance provided.

2. A rate may not be determined to be inadequate unless:

a. the rate is clearly insufficient to sustain projected losses, expenses and special assessments, and

b. the rate is unreasonably low and use of the rate by the insurer has tended or, if continued, will tend to create a monopoly in the market.

3. Unfair discrimination may be determined to exist if, after allowing for practical limitations, price differentials fail to reflect equitably the differences in expected losses and expenses. A rate may not be determined to be unfairly discriminatory because different premiums result for policyholders with like loss exposures but different expense levels, or like expenses but different loss exposures, or if it averaged broadly among persons insured within a group, franchise or blanket policy or a mass-marketed plan. No rate in a competitive market shall be considered unfairly discriminatory unless it classifies risk on the basis of race, color, creed, or national origin.

B. In determining whether rates in a noncompetitive market are excessive, inadequate, or unfairly discriminatory, due consideration may be given to:

1. Past and prospective loss experience within and outside this state, in accordance with accepted actuarial principles;

2. Conflagration and catastrophe hazards;

3. A reasonable margin for underwriting profit and contingencies;

4. Loadings for leveling premium rates over time for dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers;

5. Past and prospective expenses both countrywide and those specially applicable to this state; and

6. Provisions for special assessments; and to all other relevant factors including judgment within and outside this state.

C. Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions, or both. Such standards may measure any differences among risks that can be demonstrated to have a probable effect upon losses or expenses. No risk classification however, may be based on race, creed, national origin, or the religion of the insured.

D. The expense provisions included in the rates for use by an insurer or group of insurers may differ from those of any other insurer or group of insurers to reflect the requirements of the operating methods of the insurer or group of insurers.

E. The rates may contain provision for contingencies and an allowance permitting a reasonable profit. In determining the reasonableness of the profit, consideration shall be given to the investment income attributable to the line of insurance.

F. Risks may be classified in any way except that no risk may be classified on the basis of race, color, creed, or national origin.

Added by Laws 1999, c. 83, § 5, eff. Nov. 1, 1999. Amended by Laws 2004, c. 519, § 16, eff. Nov. 1, 2004.

§36-985.1. Regulation of rates in market without competition.

A. If the Commissioner determines that competition does not exist in a market and issues a ruling to that effect pursuant to Section 984 of Title 36 of the Oklahoma Statutes, the rates applicable to insurance sold in that market shall be regulated in accordance with the provisions of Sections 985 through 989 of Title 36 of the Oklahoma Statutes that are applicable to noncompetitive markets.

B. Any rate in effect at the time the Commissioner determines that competition does not exist pursuant to Section 984 of Title 36 of the Oklahoma Statutes shall be deemed to be in compliance with the laws of this state unless disapproved pursuant to the procedures and rating standards contained in Sections 985 through 989 of Title 36 of the Oklahoma Statutes that are applicable to noncompetitive markets.

C. Any insurer having a rate filing in effect at the time the Commissioner determines that competition does not exist pursuant to Section 984 of Title 36 of the Oklahoma Statutes may be required to furnish supporting information within thirty (30) days of a written request by the Commissioner.

Added by Laws 2004, c. 519, § 17, eff. Nov. 1, 2004.

§36-986. Rate administration.

Rate Administration.

A. In only those markets found to be noncompetitive pursuant to Section 984 of this title, insurers and advisory organizations shall file with the Commissioner and the Commissioner shall review reasonable rules and plans for recording and reporting their rates, loss and expense experience and other information determined by the Commissioner to be necessary or appropriate for the administration of the Property and Casualty Competitive Loss Cost Rating Act. The Commissioner may designate one or more advisory organizations or other agencies to assist in gathering such experience and making compilation thereof.

B. Reasonable rules and plans may be promulgated by the Commissioner for the exchange of data necessary for the development and application of rating plans.

C. In order to further uniform administration of rate regulatory laws, the Commissioner and every insurer and advisory organization may exchange information and experience data with insurance supervisory officials, insurers and advisory organizations in other states and may consult with them with respect to the application of rating systems.

D. Cooperation among advisory organizations or among advisory organizations and insurers in ratemaking or in other matters within the scope of the Property and Casualty Competitive Loss Cost Rating Act is authorized. The Commissioner may review such cooperative activities and practices, and if, after a hearing, any such activity or practice is found to violate the provisions of the Property and Casualty Competitive Loss Cost Rating Act, a written order may be issued specifying that such activity or practice violates the provisions of this act and requiring the discontinuance of such activity.

Added by Laws 1999, c. 83, § 6, eff. Nov. 1, 1999. Amended by Laws 2004, c. 519, § 18, eff. Nov. 1, 2004.

§36-987. Rate filings.

Rate Filings.

A. In a competitive market, every insurer shall file with the Commissioner all rates and supplementary rate information to be used in this state no later than thirty (30) days after the effective date; provided, that the rates and supplementary rate information

need not be filed for commercial risks, which by general custom are not written according to manual rules or rating plans.

B. In a noncompetitive market, every insurer shall file with the Commissioner all rates, supplementary rate information and supporting information at least thirty (30) days before the proposed effective date. The Commissioner may give written notice, within thirty (30) days of receipt of the filing, that the Commissioner needs additional time, not to exceed thirty (30) days from the date of the notice to consider the filing. Upon written application of the insurer, the Commissioner may authorize rates to be effective before the expiration of the waiting period or an extension thereof. A filing shall be deemed to meet the requirements of the Property and Casualty Competitive Loss Cost Rating Act and to become effective unless disapproved pursuant to this title by the Commissioner before the expiration of the waiting period or an extension thereof.

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

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

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

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

F. A filing and any supporting information required to be filed shall be open to public inspection once the filing becomes effective

except information marked confidential, trade secret, or proprietary by the insurer or filer and except the filings of an advisory organization which shall be open to public inspection upon the received date of the rate, loss cost, or manual rule change. The insurer or filer shall have the burden of asserting to the Commissioner that a filing and supporting information are confidential, upon the request of the Commissioner. The Commissioner may disapprove of the insurer's request for confidential filing status.

Added by Laws 1999, c. 83, § 7, eff. Nov. 1, 1999. Amended by Laws 2004, c. 519, § 19, eff. Nov. 1, 2004; Laws 2005, c. 129, § 7, eff. Nov. 1, 2005; Laws 2007, c. 125, § 2, eff. July 1, 2007; Laws 2008, c. 184, § 7, eff. July 1, 2008.

§36-988. Repealed by Laws 2004, c. 519, § 37, eff. Nov. 1, 2004.

§36-989. Improper rates - Disapproval - Hearing.

Improper Rates; Disapproval; Hearing.

A. Basis for disapproval.

1. The Commissioner shall disapprove a rate in a competitive market only if the Commissioner finds, pursuant to subsection B of this section, that the rate is inadequate or unfairly discriminatory pursuant to Section 985 of this title.

2. The Commissioner may disapprove a rate for use in a noncompetitive market only if the Commissioner finds, pursuant to subsection B of this section, that the rate is excessive, inadequate or unfairly discriminatory under this subsection.

B. Procedures for disapproval.

1. Prior to the expiration of a waiting period or an extension thereof, made pursuant to subsection B of Section 987 of this title, the Commissioner may disapprove, by written order, rates filed pursuant to subsection B of Section 987 of this title with a hearing. The order shall specify in what respects the filing fails to meet the requirements of this act. Any insurer whose rates are disapproved pursuant to this section shall be given a hearing upon written request made within thirty (30) days of disapproval.

2. If, at any time, the Commissioner finds that a rate applicable to insurance sold in a noncompetitive market does not comply with the standards set forth in Section 985 of this title, the Commissioner may, after a hearing held upon not less than twenty (20) days' written notice, issue an order pursuant to subsection C of this section, disapproving such rate. The hearing notice shall be sent to every insurer and advisory organization that adopted the rate and shall specify the matters to be considered at the hearing. The disapproval order shall not affect any contract or policy made or issued prior to the effective date set forth in the order.

3. If, at any time, the Commissioner finds that a rate applicable to insurance sold in a competitive market is inadequate or unfairly discriminatory under paragraph 2 or 3 of subsection A of Section 985 of this title, the Commissioner may issue an order pursuant to subsection C of this section disapproving the rate. The order shall not affect any contract or policy made or issued prior to the effective date set forth in the order.

C. Order of disapproval.

If the Commissioner disapproves a rate pursuant to subsection B of this section, the Commissioner shall issue an order within thirty (30) days of the close of the hearing specifying in what respects the rate fails to meet the requirements of this act. The order shall state an effective date no sooner than thirty (30) business days after the date of the order when the use of the rate shall be discontinued. This order shall not affect any policy made before the effective date of the order.

D. Appeal of orders and establishment of reserves.

If an order of disapproval is appealed pursuant to Section 990 of this title, the insurer may implement the disapproved rate upon notification to the court, in which case any excess of the disapproved rate over a rate previously in effect shall be placed in a reserve established by the insurer. The court shall have control over the disbursement of funds from such reserve. The funds shall be distributed as determined by the court in its final order except that de minimus refunds to policyholders shall not be required.

E. All determinations made by the Commissioner under this section shall be on the basis of findings of fact and conclusions of law.

Added by Laws 1999, c. 83, § 9, eff. Nov. 1, 1999. Amended by Laws 2004, c. 519, § 20, eff. Nov. 1, 2004.

§36-990. Challenge and review of application of rating system.

Challenge and Review of Application of Rating System.

A. Every advisory organization and every insurer subject to the Property and Casualty Competitive Loss Cost Rating Act which makes its own rates shall provide within this state reasonable means whereby any insured aggrieved by the application of its rating system may, upon that insured's written request, be heard in person or by the insured's authorized representative to review the manner in which such rating system has been applied in connection with the insurance afforded the aggrieved insurer.

B. An insurer or any party affected by the action of an advisory organization may, within thirty (30) days after written notice of that action, make application, in writing, for an appeal to the Commissioner, setting forth the basis for the appeal and the grounds to be relied upon by the applicant.

C. Within thirty (30) days, the Commissioner shall review the application and, if the Commissioner finds that the application is made in good faith and that it sets forth on its face grounds which reasonably justify holding a hearing, the Commissioner shall conduct a hearing held not less than ten (10) days after written notice to the applicant and to the advisory organization or insurer. The Commissioner, after a hearing, shall affirm or reverse the action of the advisory organization or insurer.
Added by Laws 1999, c. 83, § 10, eff. Nov. 1, 1999. Amended by Laws 2004, c. 519, § 21, eff. Nov. 1, 2004.

§36-991. Repealed by Laws 2006, c. 264, § 82, eff. July 1, 2006.

§36-992. Insurers - Prohibited activity.

Insurers; Prohibited Activity.

A. No insurer shall:

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

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

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

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

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

Added by Laws 1999, c. 83, § 12, eff. Nov. 1, 1999. Amended by Laws 2005, c. 129, § 9, eff. Nov. 1, 2005; Laws 2007, c. 125, § 3, eff. July 1, 2007.

§36-993. Repealed by Laws 2006, c. 264, § 82, eff. July 1, 2006.

§36-994. Advisory organizations - Filing requirements.

Advisory Organizations; Filing Requirements.

Every advisory organization shall file with the Commissioner for approval every statistical plan, all prospective loss costs, provisions for special assessments and all supplementary rating information and every change or amendment or modification of any of the foregoing proposed for use in this state at least thirty (30) days prior to its effective date. Such filings will be deemed approved unless disapproved within the waiting period.
Added by Laws 1999, c. 83, § 14, eff. Nov. 1, 1999.

§36-995. Joint underwriting, joint reinsurance pool and residual market activities.

Joint Underwriting, Joint Reinsurance Pool and Residual Market Activities.

A. Notwithstanding paragraph 3 of subsection A of Section 992 of this title, insurers participating in joint underwriting, joint reinsurance pools or residual market mechanisms may in connection with such activity act in cooperation with each other in the making of rates, rating systems, policy forms, underwriting rules, surveys, inspections and investigations, the furnishing of loss and expense statistics or other information, or carrying on research. Joint underwriting, joint reinsurance pools and residual market mechanisms shall not be deemed an advisory organization.

B. Except to the extent modified by this section, joint underwriting, joint reinsurance pool and residual market mechanism activities are subject to the other provisions of the Property and Casualty Competitive Loss Cost Rating Act.

C. If, after a hearing, the Commissioner finds that any activity or practice of an insurer participating in joint underwriting or a pool is unfair, is unreasonable, will tend to lessen competition in any market or is otherwise inconsistent with the provisions or purposes of the Property and Casualty Competitive Loss Cost Rating Act, the Commissioner may issue a written order and require the discontinuance of such activity or practice.

D. Every pool shall file with the Commissioner a copy of its constitution, articles of incorporation, agreement or association, bylaws, rules and regulations governing its activities, list of members, the name and address of a resident of this state upon whom notice, orders of the Commissioner, or process may be served, and any changes in amendments or changes in the foregoing.

E. Any residual market mechanism, plan or agreement to implement such a mechanism, and any changes or amendments thereto, shall be submitted in writing to the Commissioner for consideration and approval, together with such information as may be reasonably required.

Added by Laws 1999, c. 83, § 15, eff. Nov. 1, 1999. Amended by Laws 2007, c. 125, § 4, eff. July 1, 2007; Laws 2013, c. 254, § 18, eff. Jan. 1, 2015; Laws 2022, c. 304, § 1, eff. Nov. 1, 2022.

§36-996. Assigned risks.

Assigned Risks. A. Agreements may be made among insurers with respect to the equitable apportionment among them of costs for insurance which may be afforded applicants who are in good faith entitled to, but who are unable to procure, such insurance through ordinary methods, and such insurers may agree among themselves on the use of reasonable rate modifications for such insurance, such agreements and rate modifications to be subject to the approval of the Insurance Commissioner.

B. The Oklahoma Automobile Insurance Plan is authorized to issue policies of insurance in the name of the plan for the applicants described in subsection A of this section and to act on behalf of all participating members in connection with the policies. The policies shall be considered proof of financial responsibility in accordance with Section 7-600 of the Highway Safety Code.

C. The participating members shall be liable to the plan for all costs, expenses and liabilities in proportion to its share of voluntary market premium for the types of policies written under the plan in this state.

D. The plan shall file an annual audited financial statement with the Commissioner.

E. The Commissioner is authorized to establish rules and regulations required to implement the purposes of this section. Added by Laws 1999, c. 83, § 16, eff. Nov. 1, 1999. Amended by Laws 2007, c. 125, § 5, eff. July 1, 2007; Laws 2021, c. 478, § 4, emerg. eff. May 12, 2021.

§36-996.1. Assigned risk plans.

After consultation with the insurance companies authorized to issue automobile liability policies in this state, the Insurance Commissioner shall approve a reasonable plan or plans, fair to the insurers and equitable to their policyholders, for the apportionment among such companies of applicants for such policies and for motor vehicle liability policies who are in good faith entitled to but are unable to procure such policies through ordinary methods. When any such plan has been approved, all such insurance companies shall subscribe thereto and participate therein. Any applicant for any such policy, any person insured under any such plan, and any insurance company affected may appeal to the Insurance Commissioner from any ruling or decision of the manager or committee designated to operate such plan. Any order or act of the Insurance Commissioner under the provisions of this section shall be subject to review by appeal to the district court of Oklahoma County at the

instance of any party in interest. The court shall determine whether the filing of the appeal shall operate as a stay of any such order or act of the Insurance Commissioner and the court shall summarily hear the matter. The court may, in disposing of the issue before it, modify, affirm or reverse the order or act of the Insurance Commissioner in whole or in part.

Added by Laws 1961, p. 365, § 7-501. Renumbered from Title 47, § 7-501 by Laws 2009, c. 62, § 40, eff. Nov. 1, 2009.

§36-997. Commercial special risks.

Commercial Special Risks.

A. The following categories of commercial lines risks, excluding employer's liability line, workers' compensation and excess workers' compensation, are special risks and are exempted from the filing and review requirements set forth in Section 987 of this title:

1. Risks which are written on an excess or umbrella basis;
2. Commercial lines insurance risks which produce a minimum annual premium total of Ten Thousand Dollars (\$10,000.00); and
3. Specifically designated special risks, including:
 - a. risks insured under the provisions of the Highly Protected Risks Rating Plan,
 - b. all commercial insurance aviation risks,
 - c. all credit insurance risks,
 - d. all boiler, machinery or equipment breakdown risks,
 - e. all inland marine risks,
 - f. all fidelity and surety risks, and
 - g. any other risk that the Commissioner determines to fall within the special risk category.

B. Underwriting files, premiums, loss and expense statistics, financial and other records with regard to special risks written by an insurer shall be maintained by the insurer and shall be subject to examination by the Commissioner.

Added by Laws 1999, c. 83, § 17, eff. Nov. 1, 1999. Amended by Laws 2006, c. 264, § 26, eff. July 1, 2006; Laws 2010, c. 222, § 9, eff. Nov. 1, 2010.

§36-998. Appeals from Commissioner.

Appeals from Commissioner.

A. Any party aggrieved by an order or decision of the Commissioner may, within thirty (30) days after receiving the Commissioner's notice, make written request for a hearing.

B. Any order, decision or act of the Commissioner pursuant to the Property and Casualty Competitive Loss Cost Rating Act is subject to judicial review upon petition of any person aggrieved. The appeal shall be in accordance with the Administrative Procedures Act.

Added by Laws 1999, c. 83, § 18, eff. Nov. 1, 1999. Amended by Laws 2007, c. 125, § 6, eff. July 1, 2007.

§36-999. Examination to ascertain compliance - Records - Cost - Report of examination in another state.

A. The Commissioner may examine any insurer, pool, advisory organization, or residual market mechanism to ascertain compliance with the Property and Casualty Competitive Loss Cost Rating Act.

B. Every insurer, pool, advisory organization, and residual market mechanism shall maintain adequate records from which the Commissioner may determine compliance with the provisions of the Property and Casualty Competitive Loss Cost Rating Act. The records shall contain the experience, data, statistics and other information collected or used and shall be available to the Commissioner for examination or inspection upon reasonable notice.

C. The reasonable cost of an examination made pursuant to this section shall be paid by the examined party upon presentation to the party of a detailed account of the costs.

D. The Commissioner may accept the report of an examination made by an insurance supervisor official of another state in lieu of an examination pursuant to this section.

Added by Laws 2004, c. 519, § 22, eff. Nov. 1, 2004.

§36-999.1. Short title.

Sections 1 through 7 of this act shall constitute Article 9C of the Insurance Code and shall be known and may be cited as the "Oklahoma Subsidence Insurance Act".

Added by Laws 2005, c. 118, § 1, eff. Jan. 1, 2006.

§36-999.2. Purpose of act.

The purpose of the Oklahoma Subsidence Insurance Act is to make mine subsidence insurance coverage available for residences, living units and commercial buildings located in this state.

Added by Laws 2005, c. 118, § 2, eff. Jan. 1, 2006.

§36-999.3. Definitions.

As used in the Oklahoma Subsidence Insurance Act:

1. "Commercial building" means any building, other than a residence or living unit, permanently affixed to realty located in this state, including basements, footings, foundations, septic systems and underground pipes directly servicing the building, but does not include sidewalks, driveways, parking lots, swimming pools, patios, pilings, piers, wharves, docks, retaining walls, fences, land, trees, plants, crops or agricultural field drainage tile;

2. "Commercial coverage" means mine subsidence insurance for a commercial building;

3. "Insurer" or "insurers" means insurance companies and reciprocals licensed and authorized to write homeowner's insurance and commercial property insurance policies in this state;

4. "Living unit" means the physical portion designated for separate ownership or occupancy for residential purposes, of a building or group of buildings, permanently affixed to realty located in this state, having elements which are owned or used in common, including an apartment unit, a condominium unit, a cooperative unit or any other similar unit, including appurtenant structures, basements, footings, foundations, septic systems and underground pipes directly servicing the dwelling or building, but does not include swimming pools, patios, pilings, wharves, docks, retaining walls, fences, sidewalks, driveways, land, trees, plants, crops or agricultural field drainage tile;

5. "Living unit coverage" means mine subsidence insurance for a living unit;

6. "Mine subsidence" means lateral or vertical ground movement caused by a failure initiated at the mine level, of man-made underground mines, including, but not limited to, coal mines, clay mines, lead and zinc mines, limestone mines, and fluorspar mines that directly damage residences or commercial buildings. "Mine subsidence" does not include lateral or vertical ground movement caused by earthquake, landslide, volcanic eruption, soil conditions, soil erosion, soil freezing and thawing, improperly compacted soil, construction defects, roots of trees and shrubs or collapse of storm and sewer drains and rapid transit tunnels;

7. "Policy" or "policies" means any contract or contracts of insurance providing the coverage of the Standard Fire Policy and Extended Coverage Endorsement on any residence, living unit or commercial building. It does not include those insurance contracts that are referred to as marine or inland marine policies;

8. "Residence" means a building used principally for residential purposes up to and including a four-family dwelling, permanently affixed to realty located in Oklahoma, including appurtenant structures, basements, footings, foundations, septic systems and underground pipes directly servicing the dwelling or building, but does not include living units, swimming pools, patios, pilings, wharves, docks, retaining walls, fences, sidewalks, driveways, land, trees, plants, crops or agricultural field drainage tile; and

9. "Residential coverage" means mine subsidence insurance for a residence.

Added by Laws 2005, c. 118, § 3, eff. Jan. 1, 2006.

§36-999.4. Subsidence coverage for residences, living units and commercial buildings - Exemption.

A. Beginning January 1, 2006, every insurer, as defined by Section 3 of this act, may offer mine subsidence coverage, upon the request by the policyholder, on policies, as defined by Section 3 of this act, issued or renewed, insuring residences, living units and commercial buildings.

B. The Insurance Commissioner may exempt policies insuring residences, living units or commercial buildings located in any specified county of this state from the provisions of this section if the Commissioner determines that such coverage is not necessary for a specified county.

Added by Laws 2005, c. 118, § 4, eff. Jan. 1, 2006.

§36-999.5. Coverage for additional living expenses.

The residential coverage provided pursuant to the Oklahoma Subsidence Insurance Act may also cover the additional living expenses reasonably and necessarily incurred by the owner of a residence who has been temporarily displaced as the direct result of damage to the residence caused by mine subsidence if the underlying policy also covers this type of loss; provided, however, that the loss covered under living unit coverage shall be limited to losses to improvements and betterments and reimbursement of additional living expenses and assessments made against the insured on account of mine subsidence loss.

Added by Laws 2005, c. 118, § 5, eff. Jan. 1, 2006.

§36-999.6. Refusal to cover unrepaired damage.

An insurer may refuse to provide mine subsidence coverage on a residence, living unit or commercial building evidencing unrepaired mine subsidence damage until such damage has been repaired.

Added by Laws 2005, c. 118, § 6, eff. Jan. 1, 2006.

§36-999.7. Right of subrogation.

All insurers issuing mine subsidence policies shall retain the right of subrogation.

Added by Laws 2005, c. 118, § 7, eff. Jan. 1, 2006.

§36-1000. Repealed by Laws 2006, c. 264, § 82, eff. July 1, 2006.

§36-1001. Judicial review.

Any order, ruling, finding, decision or other act of the Oklahoma Insurance Department made pursuant to the Property and Casualty Competitive Loss Cost Rating Act shall be subject to judicial review.

Added by Laws 2004, c. 519, § 24, eff. Nov. 1, 2004. Amended by Laws 2007, c. 125, § 7, eff. July 1, 2007.

§36-1100. Short title - Purpose and effect.

A. Sections 1100 through 1120 of Title 36 of the Oklahoma Statutes shall be known and may be cited as the "Unauthorized Insurers and Surplus Lines Insurance Act".

B. The purpose and effect of the Unauthorized Insurers and Surplus Lines Insurance Act shall relate back to the effective date of implementation of the Nonadmitted and Reinsurance Reform Act of 2010.

Added by Laws 2011, c. 278, § 4 and Laws 2011, c. 360, § 4. Amended by Laws 2012, c. 45, § 1, emerg. eff. April 16, 2012.

NOTE: Laws 2011, c. 278, § 4 and Laws 2011, c. 360, § 4 created identical new sections in Title 36.

§36-1100.1. Definitions.

As used in the Unauthorized Insurers and Surplus Lines Insurance Act:

1. "Admitted insurer" means, with respect to a state, an insurer that is licensed to transact the business of insurance in such state;

2. "Home state" means:

- a. except as provided in subparagraphs b through e of this paragraph, with respect to an insured:
 - (1) the state in which an insured maintains its principal place of business or, in the case of an individual, the individual's principal residence, or
 - (2) if one hundred percent (100%) of the insured risk is located out of the state referred to in division (1) of this subparagraph, the state to which the greatest percentage of the insured's taxable premium for the insurance contract is allocated,
- b. with respect to determining the home state of the insured, "principal place of business" means:
 - (1) the state where the insured maintains its headquarters and where the insured's high-level officers direct, control and coordinate the business activities, or
 - (2) if the insured maintains its headquarters or the insured's high-level officers direct, control and coordinate the business activities outside Oklahoma, the state to which the greatest percentage of the insured's taxable premium for that insurance contract is allocated,
- c. with respect to determining the home state of the insured, "principal residence" means:

- (1) the state where the insured resides for the greatest number of days during the calendar year, or
 - (2) if the insured's principal residence is located outside any state, the state to which the greatest percentage of the insured's taxable premium for that insurance is allocated,
- d. if more than one insured from an affiliated group are named insureds on a single nonadmitted insurance contract, the term "home state" means the home state, as determined pursuant to division (1) of subparagraph a of this paragraph, of the member affiliated group that has the largest percentage of premium attributed to it under such insurance contract, or
- e. when the group policyholder pays one hundred percent (100%) of the premium from its own funds, the term "home state" means the home state, as determined pursuant to division (1) of subparagraph a of this paragraph, of the group policyholder. When the group policyholder does not pay one hundred percent (100%) of the premium from its own funds, the term "home state" means the home state, as determined pursuant to division (1) of subparagraph a of this paragraph, or of the group member;

3. "Independently procured insurance" means insurance procured by an insured directly from a nonadmitted insurer;

4. "Licensed" means, with respect to an insurer, authorization to transact the business of insurance in a state by a license, certificate of authority, charter or otherwise;

5. "Multistate risk" means a risk covered by a nonadmitted insurer with insured exposures in more than one state;

6. "Nonadmitted insurance" means any property and casualty insurance permitted in a state to be placed directly through a surplus lines licensee or broker with a nonadmitted insurer eligible to accept such insurance. For purposes of the Unauthorized Insurers and Surplus Lines Insurance Act, nonadmitted insurance includes independently procured insurance and surplus lines insurance;

7. "Nonadmitted insurer" means, with respect to a state, an insurer not licensed to engage in the business of insurance in such state, but shall not include a risk retention group as that term is defined under applicable federal law;

8. "Single-state risk" means a risk insured with insured exposures in only one state;

9. "Surplus lines insurance" means insurance procured by a nonadmitted licensee or broker from a surplus lines insurer as permitted under the law of the insured's home state; and

10. "Surplus lines licensee" or "surplus lines broker" means an individual, firm or corporation that is licensed in the insured's home state to sell, solicit, or negotiate insurance, including the agent of record on a nonadmitted insurance policy, on properties, risks or exposures located or to be performed in a state allowing nonadmitted insurers to do business.

Added by Laws 2011, c. 278, § 5. Amended by Laws 2011, c. 360, § 5; Laws 2012, c. 45, § 2, emerg. eff. April 16, 2012.

§36-1100.2. Authority to enter multistate agreements.

A. For the purposes of carrying out the Nonadmitted and Reinsurance Reform Act of 2010, the Insurance Commissioner is authorized in the Insurance Commissioner's sole discretion and judgment to enter into the Nonadmitted Insurance Multi-State Agreement or any other multistate agreement or compact with the same function and purpose, in order to:

1. Facilitate the collection, allocation and disbursement of premium taxes attributable to the placement of nonadmitted insurance through a central clearinghouse;

2. Provide for uniform methods of allocation and reporting among nonadmitted insurance risk classifications through a central clearinghouse; and

3. Share information among states relating to nonadmitted insurance premium taxes.

B. The Insurance Commissioner is not compelled now or in the future to join the Nonadmitted Insurance Multi-State Agreement or any other multistate agreement or compact with the same function and purpose of distributing surplus line premium tax proceeds based on a formula of multistate risk allocation, unless the Insurance Commissioner, in his or her discretion, deems joining such a multistate compact or agreement is in the best interest of the State of Oklahoma and its citizens.

Added by Laws 2011, c. 278, § 6. Amended by Laws 2011, c. 360, § 6; Laws 2012, c. 45, § 3, emerg. eff. April 16, 2012.

§36-1101. Representation of unauthorized insurers prohibited.

A. No person in Oklahoma shall in any manner:

1. Represent or assist any nonadmitted insurer in the soliciting, procuring, placing, or maintenance of any nonadmitted insurance coverage upon or with relation to any subject of insurance resident, located, or to be performed in Oklahoma without being a surplus lines licensee or broker as defined in the Unauthorized Insurers and Surplus Lines Insurance Act; or

2. Inspect or examine any risk or collect or receive any premium on behalf of any nonadmitted insurer without being a surplus lines broker or licensee as defined in the Unauthorized Insurers and Surplus Lines Insurance Act.

B. Any person transacting insurance or acting as a surplus lines broker or licensee in violation of this section shall be liable to the insured for the performance of any contract between the insured and the insurer resulting from the transaction.

C. This section shall not apply as to reinsurance, to surplus line insurance lawfully procured pursuant to the Unauthorized Insurers and Surplus Lines Insurance Act, to transactions exempt under Section 606 of this title (Authorization of Insurers and General Qualifications), or to professional services of an adjuster or attorney-at-law from time to time with respect to claims under policies lawfully solicited, issued, and delivered outside of Oklahoma.

D. The investigation and adjustment of any claim in this state arising under an insurance contract issued by a nonadmitted insurer shall not be deemed to constitute the transacting of the business of insurance in this state.

E. Nonadmitted insurers shall contract with the trustees of any fund which will insure residents in this state in a manner consistent with the requirements, nature and scope of the Unauthorized Insurers and Surplus Lines Insurance Act.

Added by Laws 1957, p. 256, § 1101, operative July 1, 1957. Amended by Laws 1976, c. 98, § 1, emerg. eff. May 10, 1976; Laws 2010, c. 222, § 10, eff. Nov. 1, 2010; Laws 2011, c. 278, § 7 and Laws 2011, c. 360, § 7; Laws 2012, c. 45, § 4, emerg. eff. April 16, 2012.

NOTE: Laws 2011, c. 278, § 7 and Laws 2011, c. 360, § 7 made identical changes to this section.

§36-1101.1. Domestic surplus line insurers.

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 may write surplus line insurance in this state and in any other jurisdiction allowed under the Nonadmitted and Reinsurance Reform Act of 2010.

B. The premiums of a domestic surplus line insurer shall be subject to surplus line premium tax pursuant to Section 1115 of this title. The surplus lines broker or licensee shall pay all premium taxes to the Insurance Commissioner when Oklahoma is the home state of the insured until and unless in the exercise of his or her sole discretion and judgment, the Insurance Commissioner decides to join the Nonadmitted Insurance Multi-State Agreement or any other multistate agreement or compact with the same function and purpose.

C. A domestic surplus line insurer may not issue a policy designed to satisfy the motor vehicle financial responsibility requirement of this state, the Workers' Compensation Code, 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 Association Act nor the Oklahoma Life and Health Insurance Guaranty Association Act.

Added by Laws 2009, c. 176, § 22, eff. Nov. 1, 2009. Amended by Laws 2011, c. 278, § 8; Laws 2011, c. 360, § 8; Laws 2012, c. 45, § 5, emerg. eff. April 16, 2012; Laws 2012, c. 365, § 1, emerg. eff. June 8, 2012.

§36-1102. Validity of contracts effectuated by a surplus lines insurer.

A contract of insurance effectuated by a surplus lines insurer in violation of this Code shall be voidable except at the instance of the insured.

Added by Laws 1957, p. 256, § 1102, operative July 1, 1957. Amended by Laws 2010, c. 222, § 11, eff. Nov. 1, 2010; Laws 2015, c. 49, § 1, eff. Nov. 1, 2015.

§36-1103. Service of process on a surplus lines insurer.

A. Delivery, effectuation, or solicitation of any insurance contract, by mail or otherwise, within this state by a surplus lines insurer, or the performance within this state of any other service or transaction connected with the insurance by or on behalf of the insurer, shall be deemed to constitute an appointment by the insurer of the Insurance Commissioner as its attorney, upon whom may be served all lawful process issued within this state in any action or proceeding against the insurer arising out of any such contract or transaction.

B. Service of process shall be made by delivering to and leaving with the Insurance Commissioner three copies thereof. At time of service the plaintiff shall pay Twenty Dollars (\$20.00) to the Insurance Commissioner, taxable as costs in the action. The Insurance Commissioner shall mail by registered mail one of the copies of the process to the defendant at any home state address as last known to the Insurance Commissioner, and shall keep a record of all process so served.

C. Service of process in any action or proceeding, in addition to the manner provided herein, shall also be valid if served upon any person within this state who, in this state on behalf of the insurer, is soliciting insurance, or making, issuing, or delivering any insurance policy, or collecting or receiving any premium, membership fee, assessment, or other consideration for insurance.

D. Service of process upon an insurer in accordance with this section shall be as valid and effective as if served upon a defendant personally present in this state.

E. Means provided in this section for service of process upon the insurer shall not be deemed to prevent service of process upon the insurer by any other lawful means.

F. An insurer which has been so served with process shall have the right to appear in and defend the action and employ attorneys and other persons in this state to assist in its defense or settlement.

Added by Laws 1957, p. 256, § 1103, operative July 1, 1957. Amended by Laws 1985, c. 328, § 8, emerg. eff. July 29, 1985; Laws 1997, c. 418, § 38, eff. Nov. 1, 1997; Laws 2010, c. 222, § 12, eff. Nov. 1, 2010; Laws 2011, c. 278, § 9 and Laws 2011, c. 360, § 9; Laws 2012, c. 45, § 6, emerg. eff. April 16, 2012.

NOTE: Laws 2011, c. 278, § 9 and Laws 2011, c. 360, § 9 made identical changes to this section.

§36-1104. Exemptions from service of process provisions.

Sections 1103 and 1105 of this article shall not apply to reinsurance, nor to any action or proceeding against a surplus lines insurer arising out of:

1. Ocean marine and foreign trade insurance,
2. Insurance on subjects located, resident, or to be performed wholly outside this state, or on vehicles or aircraft owned and principally garaged outside this state,
3. Insurance on property or operations of railroads engaged in interstate commerce, or
4. Insurance on aircraft or cargo of the aircraft, or against liability, other than employers' liability, arising out of the ownership, maintenance, or use of the aircraft, where the policy or contract contains a provision designating the Insurance Commissioner as its attorney for the acceptance of service of lawful process in any action or proceeding instituted by or on behalf of an insured or beneficiary arising out of any policy, or where the insurer enters a general appearance in any action.

Added by Laws 1957, p. 257, § 1104, operative July 1, 1957. Amended by Laws 2010, c. 222, § 13, eff. Nov. 1, 2010; Laws 2012, c. 45, § 7, emerg. eff. April 16, 2012.

§36-1105. Attorney fees.

In any action against a surplus lines insurer pursuant to Section 1103 of this title, if the insurer has failed for thirty (30) days after demand prior to the commencement of the action to make payment in accordance with the terms of the contract of insurance or in accordance with Section 1115 of this title, and it appears to the court that the refusal was vexatious and without reasonable cause, the court may allow to the plaintiff or an aggrieved agency of this state a reasonable attorney fee and include the fee in any judgment that may be rendered in the action. The fee

shall not exceed one-third (1/3) of the amount which the court or jury finds the plaintiff is entitled to recover against the insurer, but in no event shall a fee be less than One Hundred Dollars (\$100.00). Failure of an insurer to defend any action shall be deemed prima facie evidence that its failure to make payment was vexatious and without reasonable cause.

Added by Laws 1957, p. 257, § 1105, operative July 1, 1957. Amended by Laws 2010, c. 222, § 14, eff. Nov. 1, 2010; Laws 2011, c. 278, § 10 and Laws 2011, c. 360, § 10; Laws 2012, c. 45, § 8, emerg. eff. April 16, 2012.

NOTE: Laws 2011, c. 278, § 10 and Laws 2011, c. 360, § 10 made identical changes to this section.

§36-1106. Surplus lines - Brokers.

If insurance required to protect the interest of the insured for the amount of insurance, coverage terms and solvency requirements of the insured cannot be procured from admitted insurers after inquiry in the market available to the insurance producer, then insurance may be procured from surplus lines insurers subject to the following conditions:

1. The surplus lines insurer shall meet the requirements of the Unauthorized Insurers and Surplus Lines Insurance Act and the following conditions:

- a. the insurer has capital and surplus or its equivalent under the laws of its domiciliary jurisdiction which equals the greater of:
 - (1) the minimum capital and surplus requirements under the laws of this state for nonadmitted insurers, or
 - (2) Fifteen Million Dollars (\$15,000,000.00),
- b. the requirements of subparagraph a of this paragraph may be satisfied by an insurer's possessing less than the minimum capital and surplus upon an affirmative finding of acceptability by the Insurance Commissioner. The finding shall be based upon such factors as quality of management, capital and surplus of any parent company, company underwriting profit and investment income trends, market availability and company record and reputation within the industry. In no event shall the Insurance Commissioner make an affirmative finding of acceptability when the nonadmitted insurer's capital and surplus is less than Four Million Five Hundred Thousand Dollars (\$4,500,000.00), and
- c. the insurer, if an alien insurer, is listed on the National Association of Insurance Commissioners Nonadmitted Insurers Quarterly Listing; and

2. The insurance shall be procured through a licensed surplus lines licensee or broker licensed in the insurer's home state. An Oklahoma surplus lines license is required only where Oklahoma is the home state of the insured.

For the purposes of carrying out the provisions of the Nonadmitted and Reinsurance Reform Act of 2010, the Insurance Commissioner is authorized to utilize the national insurance producer database of the National Association of Insurance Commissioners, or any other equivalent uniform national database, for the licensure of an individual or entity as a surplus lines licensee or broker and for renewal of such license.

Added by Laws 1957, p. 257, § 1106, operative July 1, 1957. Amended by Laws 1986, c. 134, § 3, emerg. eff. April 17, 1986; Laws 1991, c. 146, § 1, eff. Sept. 1, 1991; Laws 1993, c. 79, § 4, eff. Sept. 1, 1993; Laws 2006, c. 94, § 1, eff. Nov. 1, 2006; Laws 2010, c. 222, § 15, eff. Nov. 1, 2010; Laws 2011, c. 278, § 11; Laws 2011, c. 360, § 11; Laws 2012, c. 45, § 9, emerg. eff. April 16, 2012; Laws 2012, c. 365, § 2, emerg. eff. June 8, 2012; Laws 2014, c. 415, § 1, emerg. eff. June 3, 2014; Laws 2018, c. 95, § 2, eff. Nov. 1, 2018.

§36-1106.1. Due diligence search.

A. A surplus lines licensee or broker is not required to make a due diligence search to determine whether the full amount or type of insurance can be obtained from admitted insurers when the surplus lines licensee or broker is seeking to procure or place nonadmitted insurance for an exempt commercial purchaser, unless the licensee or broker procuring or placing the surplus lines insurance has disclosed to the exempt commercial purchaser that such insurance may or may not be available from the admitted market that may provide greater protection with more regulatory oversight.

B. For purposes of this section, the term "exempt commercial purchaser" means any person purchasing commercial insurance that, at the time of placement, meets the following requirements:

1. The person employs or retains a qualified risk manager to negotiate insurance coverage;

2. The person has paid aggregate nationwide commercial property and casualty insurance premiums in excess of One Hundred Thousand Dollars (\$100,000.00) in the immediately preceding twelve (12) months;

3. The person meets at least one of the following criteria:

a. the person possesses a net worth in excess of Twenty-four Million Dollars (\$24,000,000.00), as such amount is adjusted pursuant to paragraph 4 of this subsection,

b. the person generates annual revenues in excess of Sixty Million Dollars (\$60,000,000.00), as such amount

is adjusted pursuant to paragraph 4 of this subsection,

- c. the person employs more than five hundred full-time-equivalent employees per individual insured or is a member of an affiliated group employing more than one thousand employees in the aggregate,
- d. the person is a not-for-profit organization or public entity generating annual budgeted expenditures of at least Thirty-six Million Dollars (\$36,000,000.00), as such amount is adjusted pursuant to paragraph 4 of this subsection, or
- e. the person is a municipality with a population in excess of fifty thousand (50,000) persons; and

4. Effective on January 1, 2015, and every five (5) years thereafter, the amounts in subparagraphs a, b and d of paragraph 3 of this subsection shall be adjusted to reflect the percentage change for such five-year period in the Consumer Price Index of All Urban Consumers published by the Bureau of Labor Statistics of the U.S. Department of Labor.

Added by Laws 2011, c. 278, § 12 and Laws 2011, c. 360, § 12.

Amended by Laws 2012, c. 45, § 10, emerg. eff. April 16, 2012; Laws 2022, c. 154, § 1, eff. Nov. 1, 2022; Laws 2024, c. 195, § 3, eff. Nov. 1, 2024.

NOTE: Laws 2011, c. 278, § 12 and Laws 2011, c. 360, § 12 created identical sections with the same section number.

§36-1106.2. Due diligence - Flood insurance with a nonadmitted insurer.

A surplus lines licensee or broker is not required to make a due diligence search to determine whether the full amount or type of insurance can be obtained from admitted insurers when the surplus lines licensee or broker is seeking to procure or place flood insurance with a nonadmitted insurer.

Added by Laws 2015, c. 49, § 3, eff. Nov. 1, 2015.

§36-1107. Multistate risk - Required application and informational filings - Fee payments.

A. After procuring any surplus line insurance where Oklahoma is the home state and the insurance involves a multistate risk, the surplus lines licensee and broker shall submit such information relating to the transaction as may be established by the Insurance Commissioner. The data shall be provided to the Insurance Commissioner until and unless in the exercise of his or her sole discretion and judgment, the Insurance Commissioner decides to enter or join the Nonadmitted Insurance Multi-State Agreement or any other multistate agreement or compact with the same function and purpose and other reporting requirements are thereby established.

B. When Oklahoma is the home state of the insured, the surplus lines licensee or broker shall make all informational and tax filings and fee and tax payments electronically in the manner and form required or to be established by the Insurance Commissioner, along with any applicable transaction fees. When Oklahoma is the home state of the insured, the premium tax filings and premium tax payments shall be provided entirely to the Insurance Commissioner until and unless, in the exercise of his or her sole discretion and judgment, the Insurance Commissioner decides to enter or join the Nonadmitted Insurance Multi-State Agreement or any other multistate agreement or compact with the same function and purpose.

C. Failure to file the required information, any required fee payments and make the required premium tax payments in the manner established by the Insurance Commissioner pursuant to this section and Section 1115 of this title where Oklahoma is the home state of the insured shall result, after notice and hearing, in censure, suspension, or revocation of license or a fine of up to Five Hundred Dollars (\$500.00) for each occurrence or by both such fine and licensure penalty.

Added by Laws 1957, p. 257, § 1107, operative July 1, 1957. Amended by Laws 1987, c. 175, § 7, eff. Nov. 1, 1987; Laws 1991, c. 146, § 2, eff. Sept. 1, 1991; Laws 2010, c. 222, § 16, eff. Nov. 1, 2010; Laws 2011, c. 278, § 13; Laws 2011, c. 360, § 13; Laws 2012, c. 45, § 11, emerg. eff. April 16, 2012; Laws 2012, c. 365, § 3, emerg. eff. June 8, 2012; Laws 2024, c. 195, § 4, eff. Nov. 1, 2024.

§36-1108. Recognized surplus lines.

If a particular insurance coverage or type, class, or kind of coverage is not readily procurable from authorized insurers in Oklahoma, a surplus lines licensee or broker may place the coverage with a nonadmitted insurer or surplus lines insurer as defined in the Unauthorized Insurers and Surplus Lines Insurance Act.

Added by Laws 1957, p. 257, § 1108, operative July 1, 1957. Amended by Laws 2010, c. 222, § 17, eff. Nov. 1, 2010; Laws 2011, c. 278, § 14 and Laws 2011, c. 360, § 14.

NOTE: Laws 2011, c. 278, § 14 and Laws 2011, c. 360, § 14 made identical changes to this section.

§36-1109. Validity of surplus line insurance - Notice of limitations of coverage.

A. Insurance contracts procured as surplus line coverage from surplus lines insurers in accordance with this article shall be fully valid and enforceable as to all parties, and shall be given recognition in all matters and respects to the same effect as like contracts issued by admitted insurers.

B. Insurance contracts procured as surplus line coverage shall contain in bold-face type notification stamped by the surplus lines

licensee or broker or surplus lines insurer on the declaration page of the policy that the contracts are not subject to the protection of any guaranty association in the event of liquidation or receivership of the surplus lines insurer. The Commissioner is hereby authorized to promulgate rules to establish further disclosure requirements for the purpose of protecting consumers of surplus line coverage.

Added by Laws 1957, p. 258, § 1109, operative July 1, 1957. Amended by Laws 1986, c. 251, § 10, eff. Nov. 1, 1986; Laws 1991, c. 146, § 3, eff. Sept. 1, 1991; Laws 2006, c. 264, § 27, eff. July 1, 2006; Laws 2010, c. 222, § 18, eff. Nov. 1, 2010; Laws 2011, c. 278, § 15; Laws 2011, c. 360, § 15; Laws 2012, c. 45, § 12, emerg. eff. April 16, 2012; Laws 2014, c. 415, § 2, emerg. eff. June 3, 2014.

NOTE: Laws 2011, c. 278, § 15 and Laws 2011, c. 360, § 15 made identical changes to this section.

§36-1111. Acceptance of surplus line business by brokers.

A surplus lines licensee or broker may accept and place surplus lines insurance from any insurance agent or broker licensed in this state for the kind of insurance involved, and may compensate such agent or broker therefor. The insurance agent or broker shall have the right to receive from the surplus lines insurer the customary commission.

Added by Laws 1957, p. 258, § 1111, operative July 1, 1957. Amended by Laws 2011, c. 278, § 16 and Laws 2011, c. 360, § 16; Laws 2012, c. 45, § 13, emerg. eff. April 16, 2012.

NOTE: Laws 2011, c. 278, § 16 and Laws 2011, c. 360, § 16 made identical changes to this section.

§36-1112. Solvent insurer required - License revocation - Penalties.

A. A surplus lines licensee or broker shall not knowingly place any such coverage with a nonadmitted insurer which is in an unsound financial condition. To be considered financially sound, a surplus lines insurer shall meet the requirements of Section 1106 of this title.

B. For violation of this section, in addition to any other penalty provided by law, the surplus lines broker's license shall be revoked, and the broker shall not again be so licensed within a period of two (2) years thereafter. In addition, any surplus lines licensee and broker who violates this section shall be guilty of a misdemeanor and upon conviction thereof shall be punished for each offense, by a fine of not more than One Thousand Dollars (\$1,000.00) or by confinement in jail for not more than ninety (90) days, or by both such fine and imprisonment.

Added by Laws 1957, p. 258, § 1112, operative July 1, 1957. Amended by Laws 1965, c. 132, § 1, eff. Oct. 1, 1965; Laws 1991, c. 146, §

4, eff. Sept. 1, 1991; Laws 2002, c. 307, § 10, eff. Nov. 1, 2002; Laws 2011, c. 278, § 17 and Laws 2011, c. 360, § 17; Laws 2012, c. 45, § 14, emerg. eff. April 16, 2012.

NOTE: Laws 2011, c. 278, § 17 and Laws 2011, c. 360, § 17 made identical changes to this section.

§36-1113. Records of surplus lines licensees or brokers.

Each surplus lines licensee or broker licensed in Oklahoma shall keep a full and true record of each surplus lines contract procured by the surplus lines broker, and such record may be examined at any time within three (3) years thereafter by the Insurance Commissioner. The record shall include such information required to be submitted as established by the Insurance Commissioner in this article.

Added by Laws 1957, p. 258, § 1113, operative July 1, 1957. Amended by Laws 1997, c. 418, § 39, eff. Nov. 1, 1997; Laws 2011, c. 278, § 18; Laws 2011, c. 360, § 18; Laws 2012, c. 45, § 15, emerg. eff. April 16, 2012.

§36-1114. Broker's annual statement.

Each surplus lines licensee or broker licensed or transacting business in Oklahoma shall on or before April 1 of each year file electronically, along with any applicable transaction fees, with the Insurance Commissioner a verified statement of all surplus lines insurance transacted by the broker during the preceding calendar year where Oklahoma is the home state of the insured. The statement shall be on a form prescribed and furnished by the Insurance Commissioner and shall show such information required to be submitted as established by the Insurance Commissioner. The information shall be provided to the Insurance Commissioner until and unless, in the exercise of his or her sole discretion and judgment, the Insurance Commissioner decides to enter or join the Nonadmitted Insurance Multi-State Agreement or any other multistate agreement or compact with the same function and purpose and other transaction reporting requirements are thereby established.

Added by Laws 1957, p. 259, § 1114, operative July 1, 1957. Amended by Laws 2011, c. 278, § 19; Laws 2011, c. 360, § 19; Laws 2012, c. 45, § 16, emerg. eff. April 16, 2012; Laws 2024, c. 195, § 5, eff. Nov. 1, 2024.

§36-1115. Tax on surplus lines - Surplus lines insurer.

A. Where Oklahoma is the home state of the insured, every person licensed pursuant to Section 1106 of this title shall collect and pay as provided in this section a sum for premium tax based on the total gross premiums charged in connection with any broker-procured surplus lines insurance, less any return premiums, for

surplus lines insurance sold to the Oklahoma home-state insureds by the surplus lines broker or licensee.

B. Where Oklahoma is the home state of the insured and the insurance covers properties, risks or exposures located or to be performed both in and out of Oklahoma, the sum payable to the Oklahoma Insurance Commissioner shall be computed based on an amount equal to six percent (6%) of the total gross premiums whether the properties, risks or exposures are located or to be performed inside or outside Oklahoma. Any such unearned gross premium credited by the state to the surplus lines broker or licensee shall be returned to the policyholder by the broker or licensee. The surplus lines licensee or broker is prohibited from rebating, for any reason, any part of the tax.

C. Where Oklahoma is the home state of the insured, gross premiums charged for independently procured insurance, less any return premiums, are subject to a premium tax at the rate of six percent (6%) payable to the Oklahoma Insurance Commissioner, whether the properties, risks or exposures are located or to be performed inside or outside Oklahoma.

D. The Insurance Commissioner is authorized, in the exercise of his or her sole discretion and judgment, to participate in the Nonadmitted Insurance Multi-State Agreement or any other multistate agreement or compact with the same function and purpose for the function of collecting and disbursing to reciprocal states any funds collected pursuant to the Unauthorized Insurers and Surplus Lines Insurance Act applicable to other properties, risks or exposures located or to be performed outside of Oklahoma. Until such time as the Insurance Commissioner may, while not being required to, join such multistate agreement or compact, premium taxes relating to Oklahoma home-state insureds shall continue to be paid and accounted for by nonadmitted insurers through their surplus lines licensees and brokers as provided in subsections A through C of this section.

E. When the surplus lines coverage of an Oklahoma home-state insured covers properties, risks or exposures located only in Oklahoma, the surplus lines licensee or broker or self-procuring insured shall pay the surplus lines premium tax payable on such Oklahoma-only risks solely to the Oklahoma Insurance Commissioner.

F. Should the Insurance Commissioner exercise his or her sole discretion and judgment and decide to join the Nonadmitted Insurance Multi-State Agreement or any other multistate agreement or compact with the same function and purpose, the Insurance Commissioner is authorized in such event to establish a uniform, statewide rate of taxation applicable to lines of nonadmitted insurance. This rate shall encompass all existing rates of taxation, fees and assessments imposed by this state, pursuant to subsections A through C of this section and the Insurance Commissioner shall document the method by which the statewide rate is calculated. The Insurance Commissioner

is authorized to receive any monies obtained as premium tax received through any multistate agreement he or she may in the future in his or her discretion choose to join and then disburse such funds as provided by the Insurance Code and other applicable Oklahoma law.

G. Should the Insurance Commissioner exercise his or her sole discretion and decide to join the Nonadmitted Insurance Multi-State Agreement or any other multistate agreement or compact with the same function and purpose, the Insurance Commissioner is authorized in such circumstances to utilize or adopt any allocation schedule included in the Nonadmitted Insurance Multi-State Agreement or any other multistate agreement or compact the Insurance Commissioner may enter in the exercise of his or her sole discretion and judgment which schedule has the function and purpose of allocating risk and computing the tax due on the portion of premium attributable to each risk classification and to each state where properties, risks or exposures are located.

H. Policies sold to federally recognized Indian tribes shall be reported as provided in Section 1107 of this title; however, these policies shall be exempt from the surplus line premium tax to the extent that the Insurance Commissioner can identify that coverage is for risks which are wholly owned by a tribe and located within Indian Country, as defined in Section 1151 of Title 18 of the United States Code.

I. The surplus line premium tax on insurance on motor transit operations conducted between this and other states shall be paid on the total premium charged on all surplus line insurance less:

1. The portion of the premium charged for operations in other states taxing the premium of an insured where Oklahoma is the home state; or

2. The premium for operations outside of this state of an insured maintaining its headquarters office outside of this state and branch office in this state.

J. Flood insurance policies where Oklahoma is the home state of the insured and the insurance covers properties, risks or exposures located in Oklahoma shall be exempt from the surplus line premium tax.

K. Policies sold to any city or town in this state, incorporated pursuant to law, or to any school district, as defined in Section 1-108 of Title 70 of the Oklahoma Statutes, shall be exempt from the surplus lines premium tax.

Added by Laws 1957, p. 259, § 1115, operative July 1, 1957. Amended by Laws 1959, p. 134, § 1, emerg. eff. July 8, 1959; Laws 1961, p. 268, § 1, emerg. eff. July 5, 1961; Laws 1963, c. 48, § 1, emerg. eff. May 2, 1963; Laws 1965, c. 270, § 1, emerg. eff. June 23, 1965; Laws 1967, c. 194, § 1, emerg. eff. May 1, 1967; Laws 1968, c. 111, § 1, emerg. eff. April 1, 1968; Laws 1969, c. 82, § 1, emerg. eff. March 18, 1969; Laws 1970, c. 288, § 1, emerg. eff. April 27, 1970;

Laws 1971, c. 67, § 1, emerg. eff. April 12, 1971; Laws 1972, c. 54, § 1, emerg. eff. March 20, 1972; Laws 1983, c. 248, § 5, emerg. eff. June 21, 1983; Laws 1991, c. 146, § 5, eff. Sept. 1, 1991; Laws 1997, c. 418, § 40, eff. Nov. 1, 1997; Laws 1999, c. 96, § 1, emerg. eff. April 19, 1999; Laws 2009, c. 432, § 9, eff. July 1, 2009; Laws 2010, c. 222, § 19, eff. Nov. 1, 2010; Laws 2011, c. 278, § 20; Laws 2011, c. 360, § 20; Laws 2012, c. 45, § 17, emerg. eff. April 16, 2012; Laws 2012, c. 365, § 4, emerg. eff. June 8, 2012; Laws 2015, c. 49, § 2, eff. Nov. 1, 2015; Laws 2017, c. 271, § 1, eff. Nov. 1, 2017; Laws 2021, c. 561, § 1, eff. Nov. 1, 2021.

§36-1116. Penalty for failure to remit tax.

A. Any surplus lines licensee or broker who fails to remit the surplus line tax provided for by Section 1115 of this title shall be liable for a civil penalty not to exceed Twenty-five Dollars (\$25.00) for each day of delinquency, per policy. The Insurance Commissioner shall collect the tax by distraint and shall recover the penalty by an action in the name of the State of Oklahoma. The Commissioner may request the Attorney General to appear in the name of the state by relation of the Commissioner.

B. If any person, association or legal entity procuring or accepting any insurance coverage from a surplus lines insurer where Oklahoma is the home state of the insured, otherwise than through a surplus lines licensee or broker, fails to remit the surplus line tax provided for by Section 1115 of this title, the person, association or legal entity shall, in addition to the tax, be liable to a civil penalty in an amount equal to one percent (1%) of the premiums paid or agreed to be paid for the policy or policies of insurance for each calendar month of delinquency or a civil penalty in the amount of Twenty-five Dollars (\$25.00) whichever shall be the greater. The Insurance Commissioner shall collect the tax by distraint and shall recover the civil penalty in an action in the name of the State of Oklahoma. The Commissioner may request the Attorney General to appear in the name of the state by relation of the Commissioner.

Added by Laws 1957, p. 259, § 1116, operative July 1, 1957. Amended by Laws 1959, p. 135, § 1, emerg. eff. July 8, 1959; Laws 1991, c. 146, § 6, eff. Sept. 1, 1991; Laws 1992, c. 65, § 2, eff. Sept. 1, 1992; Laws 1997, c. 418, § 41, eff. Nov. 1, 1997; Laws 2009, c. 432, § 10, eff. July 1, 2009; Laws 2010, c. 222, § 20, eff. Nov. 1, 2010; Laws 2011, c. 278, § 21 and Laws 2011, c. 360, § 21; Laws 2012, c. 45, § 18, emerg. eff. April 16, 2012; Laws 2021, c. 478, § 5, emerg. eff. May 12, 2021.

NOTE: Laws 2011, c. 278, § 21 and Laws 2011, c. 360, § 21 made identical changes to this section.

§36-1118. Legal process against surplus line insurer.

A. Every surplus lines insurer issuing or delivering a surplus line policy through a surplus lines licensee or broker in this state shall conclusively be deemed thereby to have irrevocably appointed the Insurance Commissioner as its attorney for acceptance of service of all legal process, other than a subpoena, issued in this state in any action or proceeding under or arising out of the policy, and service of process upon the Insurance Commissioner shall be lawful personal service upon the surplus lines or nonadmitted insurer.

B. Each surplus line policy shall contain a provision stating the substance of subsection A of this section, and designating the person to whom the Insurance Commissioner shall mail process as provided in subsection C of this section.

C. Triplicate copies of legal process against such an insurer shall be served upon the Insurance Commissioner, and at time of service the plaintiff shall pay to the Insurance Commissioner Twenty Dollars (\$20.00), taxable as costs in the action. The Insurance Commissioner shall immediately mail one copy of the process so served to the person designated by the insurer in the policy for the purpose, by mail with return receipt requested. The surplus lines or nonadmitted insurer shall have forty (40) days after the date of mailing within which to plead, answer, or otherwise defend the action.

Added by Laws 1957, p. 260, § 1118, operative July 1, 1957. Amended by Laws 1986, c. 251, § 11, eff. Nov. 1, 1986; Laws 1997, c. 418, § 42, eff. Nov. 1, 1997; Laws 2010, c. 222, § 21, eff. Nov. 1, 2010; Laws 2011, c. 278, § 22 and Laws 2011, c. 360, § 22; Laws 2012, c. 45, § 19, emerg. eff. April 16, 2012.

NOTE: Laws 2011, c. 278, § 22 and Laws 2011, c. 360, § 22 made identical changes to this section.

§36-1119. Exemptions from surplus lines provisions.

The sections of this article relative to surplus line coverages shall not apply to reinsurance.

Laws 1957, p. 260, § 1119.

§36-1120. Records of insureds.

Upon request of the Insurance Commissioner any person in Oklahoma who is the insured under any policy issued by a surplus lines insurer upon a subject of insurance resident, located, or to be performed in Oklahoma at the time the policy was issued, or where the insured's home state is Oklahoma, shall produce for examination all policies and other documents evidencing and relating to the insurance, and shall disclose the amount of the gross premiums paid or agreed to be paid for the insurance, through whom the insurance was procured, and such other information relative to the placing of the insurance as may reasonably be required by the Insurance Commissioner.

Added by Laws 1957, p. 260, § 1120, operative July 1, 1957. Amended by Laws 2010, c. 222, § 22, eff. Nov. 1, 2010; Laws 2012, c. 45, § 20, emerg. eff. April 16, 2012.

§36-1125. Filing requirements.

A. Every property and casualty insurance company doing business in this state, unless otherwise exempted by the domiciliary commissioner, shall annually submit the opinion of an appointed actuary entitled "Statement of Actuarial Opinion". This opinion shall be filed in accordance with the appropriate NAIC Property and Casualty Annual Statement Instructions.

B. 1. Every property and casualty insurance company domiciled in this state that is required to submit a Statement of Actuarial Opinion shall annually submit an actuarial opinion summary written by the company's appointed actuary. This actuarial opinion summary shall be filed in accordance with the appropriate NAIC Property and Casualty Annual Statement Instructions and shall be considered as a document supporting the actuarial opinion required in subsection A of this section.

2. A company licensed but not domiciled in this state shall provide the actuarial opinion summary upon request.

C. 1. An actuarial report and underlying workpapers as required by the appropriate NAIC Property and Casualty Annual Statement Instructions shall be prepared to support each actuarial opinion.

2. If the insurance company fails to provide a supporting actuarial report and/or workpapers at the request of the Insurance Commissioner or the Commissioner determines that the supporting actuarial report or workpapers provided by the insurance company are otherwise unacceptable to the Commissioner, the Commissioner may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare the supporting actuarial report or workpapers.

D. The appointed actuary shall not be liable for damages to any person, other than the insurance company and the Commissioner, for any act, error, omission, decision or conduct with respect to the actuary's opinion, except in cases of fraud or willful misconduct on the part of the appointed actuary.

Added by Laws 2006, c. 264, § 28, eff. July 1, 2006.

§36-1126. Public access to documents and reports - Confidentiality.

A. The Statement of Actuarial Opinion shall be provided with the annual statement in accordance with the appropriate National Associations of Insurance Commissioners Property and Casualty Annual Statement Instructions and shall be treated as a public document.

B. 1. Documents, materials or other information in the possession or control of the Insurance Department that are

considered an actuarial report, work papers or actuarial opinion summary provided in support of the opinion, and any other material provided by the company to the Insurance Commissioner in connection with the actuarial report, work papers or actuarial opinion summary, and any work papers used by the Commissioner or any other person in the analysis of the actuarial report, work papers, other material or actuarial opinion summary provided in support of the opinion, shall be confidential by law and privileged, shall not be subject to the Oklahoma Open Records Act, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. The confidentiality and protection from discovery by subpoena provided in this paragraph shall not be construed to be extended to identical, similar or other related documents or information or to the work papers that are not deemed to be in the possession, custody or control of the Commissioner.

2. This provision shall not be construed to limit the Commissioner's authority to release the documents to the Actuarial Board for Counseling and Discipline (ABCD) so long as the material is required for the purpose of professional disciplinary proceedings and the ABCD establishes procedures satisfactory to the Commissioner for preserving the confidentiality of the documents, nor shall this section be construed to limit the Commissioner's authority to use the documents, materials or other information in furtherance of any regulatory or legal action brought as part of the Commissioner's official duties.

C. Neither the Commissioner nor any person who received documents, materials or other information while acting under the authority of the Commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials or information subject to subsection B of this section.

D. In order to assist in the performance of the Commissioner's duties, the Commissioner:

1. May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to subsection B of this section with other state, federal and international regulatory agencies, with the National Association of Insurance Commissioners and its affiliates and subsidiaries, and with state, federal and international law enforcement authorities; provided, that the recipient agrees to maintain the confidentiality and privileged status of the document, material or other information and has the legal authority to maintain confidentiality;

2. May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the National Association of Insurance Commissioners and its affiliates and subsidiaries, and from

regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

3. May enter into agreements governing sharing and use of information consistent with subsections B through D of this section.

E. No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the Commissioner under this section or as a result of sharing as authorized in subsection D of this section.

Added by Laws 2006, c. 264, § 29, eff. July 1, 2006. Amended by Laws 2010, c. 356, § 3, eff. Nov. 1, 2010; Laws 2012, c. 149, § 1, eff. Nov. 1, 2012.

§36-1140. Definitions - Licensing - Application - Duration of license.

A. "Advisory organization" means a corporation, an unincorporated association, a partnership or an individual, whether located inside or outside of this state, organized and licensed for the purpose of making rates, loss costs, rating plans, statistical collection, furnishing statistical data, policy forms and endorsements or rating systems.

B. The term "advisory organization" shall be synonymous with the terms "bureau", "statistical agent" and "rating organization".

C. No advisory organization shall provide any service relating to the loss costs, rates, rating plans, manual rules, rating systems or policy forms of any property and casualty insurance products subject to the provisions of the Oklahoma Insurance Code and no insurer shall utilize the services of such organization unless the organization has obtained a license.

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

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

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

- c. the name and address of one or more residents of this state upon whom notices, process affecting it, or orders of the Insurance Commissioner may be served,
- d. a statement showing its technical qualifications for acting in the capacity for which it seeks a license,
- e. a biography of the ownership and management of the organization, and
- f. any other relevant information and documents that the Commissioner may require.

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

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

4. Licenses issued pursuant to this section shall remain in force for one (1) year unless suspended or revoked. The Commissioner may at any time, after a hearing, revoke or suspend the license of any advisory organization that does not comply with the requirements and standards of the applicable provisions of the Insurance Code.

Added by Laws 2006, c. 264, § 30, eff. July 1, 2006.

§36-1141. Prohibited conduct.

A. No advisory organization shall:

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

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

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

B. Except as specifically permitted under the applicable provisions of the Insurance Code, no advisory organization shall compile or distribute recommendations relating to rates that include

expenses, other than loss adjustment expenses or loss-based taxes and assessments, or profit.

Added by Laws 2006, c. 264, § 31, eff. July 1, 2006.

§36-1142. Permitted activities and services.

Any licensed advisory organization, in addition to other activities not prohibited, is authorized on behalf of its members and subscribers to:

1. Develop statistical plans including territorial and class definitions;
2. Collect statistical data from members, subscribers or any other source;
3. Prepare, file and distribute prospective loss costs which may include provisions for special assessments and taxes;
4. Prepare, file and distribute factors, calculations or formulas pertaining to classification, territory, increased limits and other variables;
5. Prepare, file and distribute manuals of rating rules, rating schedules and other supplementary rating information that does not include final rates, expense provisions, profit provisions or minimum premiums;
6. Distribute information that is required or directed to be filed with the Commissioner;
7. Conduct research and on-site inspections in order to prepare classifications of public fire defenses;
8. Consult with public officials regarding public fire protection as it would affect members, subscribers and others;
9. Conduct research and collect statistics in order to discover, identify and classify information relating to causes or prevention of losses;
10. Conduct research and collect information to determine the impact of statutory and other law changes upon prospective loss costs and special assessments;
11. Prepare, file and distribute policy forms and endorsements and consult with members, subscribers and others relative to their use and application;
12. Conduct research and on-site inspections for the purpose of providing risk information relating to individual structures;
13. Conduct on-site inspections to determine rating classifications for individual insureds;
14. Collect, compile and publish past and current prices of individual insurers; provided, such information is also made available to the general public for a reasonable price;
15. Collect and compile exposure and loss experience for the purpose of individual risk experience ratings;
16. File final rates for residual market mechanisms; and

17. Furnish any other services, as approved or directed by the Insurance Commissioner, related to those enumerated in this section. Added by Laws 2006, c. 264, § 32, eff. July 1, 2006.

§36-1143. Review of advisory organization actions.

A. Every advisory organization which makes its own rates shall provide within this state reasonable means whereby any insured aggrieved by the application of its rating system may, upon that insured's written request, be heard in person or by the insured's authorized representative to review the manner in which such rating system has been applied in connection with the insurance afforded the aggrieved insurer.

B. An insurer or any party affected by the action of an advisory organization may, within thirty (30) days after written notice of that action, make application, in writing, for an appeal to the Insurance Commissioner, setting forth the basis for the appeal and the grounds to be relied upon by the applicant.

C. Within thirty (30) days, the Commissioner shall review the application and, if the Commissioner finds that the application is made in good faith and that it sets forth on its face grounds which reasonably justify holding a hearing, the Commissioner shall conduct a hearing held not less than ten (10) days after written notice to the applicant and to the advisory organization. The Commissioner, after a hearing, shall affirm or reverse the action of the advisory organization.

Added by Laws 2006, c. 264, § 33, eff. July 1, 2006.

§36-1144. Examination by Insurance Commissioner - Scope - Report by official of another state.

A. The Insurance Commissioner shall make or cause to be made, at least once in five (5) years, an examination of each advisory organization licensed in this state as provided in this act, and the Commissioner may, as often as it may deem expedient, make or cause to be made an examination of each advisory organization referred to in this act, and of each group, association, or other organization referred to in this act. The reasonable cost of any such examination shall be paid by the organization examined, upon presentation of a detailed account of such costs.

B. The officers, managers, agents and employees of such advisory organization may be examined, at any time, under oath, and shall exhibit all books, records, accounts, documents or agreements governing its method of operation.

C. In lieu of any such examination, the Commissioner may accept the report of an examination made by the insurance supervisory official of another state, pursuant to the laws of such state.

Added by Laws 2006, c. 264 § 34, eff. July 1, 2006.

§36-1145. Rules and statistical plans - Commissioner authority to promulgate - Scope.

A. The Insurance Commissioner shall promulgate rules and statistical plans adapted to each of the rating systems on file, which may be modified, from time to time, and which shall be used thereafter by each insurer in the recording and reporting of its loss and countrywide expense experience, in order that the experience of all insurers may be made available, at least annually, in such form and detail as may be necessary to aid it in determining whether rating systems comply with the standards set forth in this act.

1. Such rules and plans may also provide for the recording and reporting of expense experience items which are specially applicable to this state and are not susceptible to determination by a prorating of countrywide expense experience.

2. In promulgating such rules and plans, the Commissioner shall give due consideration to the rating system on file and, in order that such rules and plans may be as uniform as is practicable among the several states, to the rules and to the form of the plans used for such rating systems in other states.

3. No insurer shall be required to record or report its loss experience on a classification basis that is inconsistent with the rating system filed by it.

4. The Commissioner may designate one or more advisory organizations or other agencies to assist it in gathering such experience and making compilations thereof, and such compilations shall be made available, subject to reasonable rules promulgated by the Commissioner, to insurers and advisory organizations.

B. Reasonable rules and plans may be promulgated by the Commissioner for the interchange of data necessary for the application of rating plans.

C. In order to further uniform administration of rate regulatory laws, the Commissioner and every insurer and advisory organization may exchange information and experience data with insurance supervisory officials, insurers and rating organizations in other states and may consult with them with respect to ratemaking and the application of rating systems.

D. The Commissioner may make reasonable rules and regulations necessary to effect the purposes of this act.

Added by Laws 2006, c. 264, § 35, eff. July 1, 2006.

§36-1146. Withholding or providing false or fraudulent information - Prohibition - Punishment.

A. No person shall willfully withhold information from, or knowingly give false or misleading information to, the Insurance Commissioner, or any advisory organization designated by the

Commissioner, which will affect the rates or premiums chargeable under this act.

B. A person convicted of violating this section shall be guilty of a felony and, upon conviction, shall be punished by a fine of not less than One Thousand Dollars (\$1,000.00) nor more than Ten Thousand Dollars (\$10,000.00), or by imprisonment of not more than three (3) years or by both such fine and imprisonment.
Added by Laws 2006, c. 264, § 36, eff. July 1, 2006.

§36-1147. Suspension or revocation of license - Commissioner authority - Procedure.

A. The Insurance Commissioner may suspend the license of any advisory organization which fails to comply with an order of the Commissioner within the time limit established by such order, or any extension thereof which the Commissioner may grant. The Commissioner shall not suspend the license of any advisory organization for failure to comply with an order until the time prescribed for judicial review has expired or if an action for judicial review has been commenced, until the order has been affirmed or the action has been dismissed. The Commissioner may determine when a suspension of license shall become effective and when it shall terminate, unless it modifies or rescinds the suspension, or until the order upon which the suspension is based is modified, rescinded or reversed.

B. No license shall be suspended or revoked except upon a written order of the Commissioner, stating its findings of fact and conclusions of law, made after a hearing held upon not less than ten (10) days' written notice, to the person or legal entity, specifying the alleged violation.
Added by Laws 2006, c. 264, § 37, eff. July 1, 2006.

§36-1148. Adherence to loss cost filings - Application to workers' compensation insurance.

Applicable to workers' compensation insurance only, every member of, or subscriber to, a licensed advisory organization shall adhere to the loss cost filings made on its behalf by such organization within ninety (90) days of the effective date of the loss cost filing.
Added by Laws 2006, c. 264, § 38, eff. July 1, 2006.

§36-1161. Definitions.

As used in this act:

1. "Adverse tier placement" means being subject to the rates of any tier with less coverage or higher premiums than the tier within which the insured is currently insured;

2. "Federal government-sponsored health insurance program" means the TriCare program providing coverage for civilian dependents of military personnel;

3. "Health plan" means any insurance company or health maintenance organization which issues individual coverage to a resident of this state;

4. "Individual coverage" means health insurance or health maintenance organization coverage issued on other than a group or blanket basis, including an individual coverage containing coverage for a spouse, dependent, or both;

5. "Insureds" means persons enrolled under individual coverage issued by a health plan. Insureds include persons covered under a policy of personal insurance; and

6. "Personal insurance" means private passenger automobile, motorcycle, mobile homeowners, homeowners, renters and noncommercial-dwelling fire insurance policies and boat, personal watercraft, snowmobile and recreational vehicle policies.

Added by Laws 2006, c. 264, § 39, eff. July 1, 2006.

§36-1162. Reinstatement into individual health plan coverage -
Right to request - Time - Written notice.

A. No Oklahoma resident activated for military service, and no spouse or any dependents of such a resident who become eligible for a federal government-sponsored health insurance program as a result of such activation, shall be denied reinstatement into the same individual coverage with the same health plan that such resident lapsed as a result of activation or becoming covered by the federal government-sponsored health insurance program. Such resident will have the right to reinstatement in the same individual coverage without medical underwriting and in the same rating tier that the resident held prior to activation or becoming covered under the federal government-sponsored health insurance program, subject to payment of the current premium charged to other persons of the same age and gender that are covered under the same individual coverage. Except in the case of birth or adoptions that occur during the period of activation, reinstatement must be into the same membership type, or a membership type covering fewer persons, as such resident held prior to lapsing the individual coverage, and at the same or higher deductible level. The reinstatement rights shall not be available to an insured or dependents if the activated person is discharged from the military under other than honorable conditions.

B. The health plan with which the reinstatement is being requested must receive a request for such reinstatement no later than thirty (30) days following the later of deactivation or loss of coverage under the federal government-sponsored health insurance program. The health plan may request proof of loss and the timing of the loss of such government-funded coverage in order to determine

eligibility for reinstatement into the individual coverage. The effective date of the individual coverage will be the first of the month following receipt of the notice requesting reinstatement.

C. All health plans must provide written notice to the policyholder of individual coverage of the rights described in subsection A of this section and amendments thereto. In lieu of the inclusion of such notice in the individual coverage policy, an insurance company will satisfy the notification requirement by providing a single written notice either:

1. To a policyholder enrolling into the individual coverage initially after the effective date of this act, in conjunction with the enrollment process; or

2. By mailing written notice to policyholders whose coverage was effective prior to the effective date of this act no later than ninety (90) days following the effective date of this act.

Added by Laws 2006, c. 264, § 40, eff. July 1, 2006.

§36-1163. Exclusion from application for certain policies or coverage certificates.

The provisions of Section 40 of this act and amendments thereto shall not apply to any policy or certificate providing coverage for any specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care, as defined by Article 44 of Title 36 of the Oklahoma Statutes and any amendments thereto, Medicare supplement, as defined by the Insurance Commissioner by rules and regulations, vision care, short-term nonrenewable health policy or other limited-benefit supplemental insurance, nor any coverage issued as a supplement to any liability insurance, workers' compensation or similar insurance, or any insurance under which benefits are payable with or without regard to fault, whether written on a group, blanket or individual basis.

Added by Laws 2006, c. 264, § 41, eff. July 1, 2006.

§36-1164. Exclusion from application for certain unmet terms, conditions and limitations.

A. Nothing herein shall require a health plan to reinstate such resident if the health plan requires residency in an enrollment area and those residency requirements are not met after deactivation or loss of coverage under the federal government-sponsored health insurance program.

B. All terms, conditions and limitations of the individual coverage into which reinstatement is made will apply equally to all insureds enrolled in such coverage.

C. No personal insurance issued to an Oklahoma resident on active military deployment beyond the borders of the United States of America, or the spouse or any dependent of such Oklahoma

resident, shall be subject to cancellation, nonrenewal, denial of coverage, premium increase or adverse tier placement for the term of their deployment based solely upon said Oklahoma resident's military deployment.

D. The Insurance Commissioner is hereby authorized to adopt such rules and regulations as may be necessary to carry out the provisions of this act.

Added by Laws 2006, c. 264, § 42, eff. July 1, 2006.

§36-1165. Participation in employer sponsored health plan - Retired military employees.

No employer shall require any employee who is retired from a branch of the United States military and has been provided with health coverage through a federal plan to participate in employer-sponsored health insurance coverage if the health insurance coverage requires a contribution from the employee. The employee shall provide to the employer before the beginning of each plan year proof of that coverage.

Added by Laws 2012, c. 260, § 1, eff. Nov. 1, 2012.

§36-1201. Declaration of purpose.

The purpose of this article is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945 (Public Law 15, 79th Congress), by defining, or providing for the determination of, all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

Laws 1957, p. 260, § 1201.

§36-1202. Definitions.

When used in this article:

1. "Person" shall mean any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyd's insurer, Lloyd's Name, Lloyd's Syndicate Name, fraternal benefit society, and any other legal entity engaged in the business of insurance, including agents, brokers, adjusters, and prepaid vision plan organizations and insurers;

2. "Commissioner" shall mean the Insurance Commissioner of this state; and

3. "Name" shall mean any individual or corporate entity underwriting insurance for their own account through the Lloyd's of London market and any agents or employees of any such individual or corporate entity.

Added by Laws 1957, p. 260, § 1202. Amended by Laws 1996, c. 246, § 1, eff. July 1, 1996; Laws 2024, c. 360, § 15, emerg. eff. May 30, 2024.

§36-1203. Unfair methods of competition or unfair and deceptive acts or practices prohibited.

No person shall engage in this state in any trade practice which is defined in this article as, or determined pursuant to this article to be, an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.
Laws 1957, p. 260, § 1203.

§36-1204. Unfair methods of competition and unfair or deceptive acts or practices defined.

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

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

2. False information and advertising generally. Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way an advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of his or her insurance business which is untrue, deceptive or misleading. No insurance company shall issue, or cause to be issued, any policy of insurance of any type or description upon life, or property, real or personal, whenever such policy of insurance is to be furnished or delivered to the purchaser or bailee of any property, real or personal, as an inducement to purchase or bail such property, real or personal, and no other person shall advertise, offer or give free insurance,

insurance without cost or for less than the approved or customary rate, in connection with the sale or bailment of real or personal property, except as provided in Section 4101 of this title. No person that is not an insurer shall assume or use any name which deceptively infers or suggests that it is an insurer;

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

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

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

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

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

7. Unfair discrimination.

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

(b) Making or permitting any unfair discrimination between individuals of the same class and of essentially the

same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever.

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

8. Rebates.

- (a) Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any contract of insurance or agreement as to such contract other than as plainly expressed in the contract issued thereon; or paying or allowing, or giving or offering to pay, allow or give, directly or indirectly, as inducement to any contract of insurance, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract; except in accordance with an applicable rate filing, rating plan or rating system filed with and approved by the Insurance Commissioner; or giving or selling or purchasing or offering to give, sell, or purchase as inducement to such insurance, or in connection therewith, any stocks, bonds or other securities of any company, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract or receiving or accepting as inducement to contracts of insurance, any rebate of premium payable on the contract, or any special favor or advantage in the dividends or other benefit to accrue thereon, or any valuable consideration or inducement not specified in the contract.
- (b) Nothing in paragraph 7 or subparagraph (a) of this paragraph shall be construed as including within the definition of discrimination or rebates any of the following practices:
 - (1) in the case of any contract of life insurance or life annuity, paying bonuses to policyholders or

otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided that any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interest of the company and its policyholders,

- (2) in the case of life or accident and health insurance policies issued on the industrial debit or weekly premium plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expense,
- (3) making a readjustment of the rate of premium for a policy based on the loss or expense experience thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year,
- (4) in the case of life insurance companies, allowing its bona fide employees to receive a commission on the premiums paid by them on policies on their own lives,
- (5) issuing life or accident and health policies on a salary saving or payroll deduction plan at a reduced rate commensurate with the savings made by the use of such plan, and
- (6) paying commissions or other compensation to duly licensed agents or brokers, or allowing or returning to participating policyholders, members or subscribers, dividends, savings or unabsorbed premium deposits.

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

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

disapprove any insurer selected to underwrite the insurance, but any disapproval of any insurer shall be on reasonable grounds;

10. Inducements. No insurer, agent, broker, solicitor, or other person shall, as an inducement to insurance or in connection with any insurance transaction, provide in any policy for or offer, sell, buy, or offer or promise to buy, sell, give, promise, or allow to the insured or prospective insured or to any other person in his or her behalf in any manner whatsoever:

- (a) any employment,
- (b) any shares of stock or other securities issued or at any time to be issued or any interest therein or rights thereto,
- (c) any advisory board contract, or any similar contract, agreement or understanding, offering, providing for, or promising any special profits,
- (d) any prizes, goods, wares, merchandise, or tangible property of an aggregate value in excess of One Hundred Dollars (\$100.00), or
- (e) any special favor, advantage or other benefit in the payment, method of payment or credit for payment of the premium through the use of credit cards, credit card facilities, credit card lists, or wholesale or retail credit accounts of another person. The provisions of this paragraph shall not apply to individual policies insuring against loss resulting from bodily injury or death by accident as defined by Article 44 of the Oklahoma Insurance Code;

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

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

13. Deceptive use of financial institution's name in notification or solicitation. Verbally or by any other means notifying or soliciting any person in a manner that:

- (a) mentions the name of an unrelated and unaffiliated financial institution,
- (b) mentions an insurance product or the possible lack of insurance coverage,
- (c) does not mention the actual or trade name of the insurance agency or company on whose behalf the notification or solicitation is provided, and

- (d) thereby creates an impression or implication, including by omission, that the financial institution or a financial-institution-authorized entity is or may be the one making the notification or solicitation.

Nothing in this paragraph shall be interpreted to prohibit the reference to or use of the name of a financial institution made pursuant to a contractual agreement between the insurer and the financial institution; and

14. No insurer or prepaid vision plan organization as defined in Section 1 of this act which offers multiple prepaid vision plans may require as a condition of participation in any one prepaid vision plan that a vision care provider participate in any of the other prepaid vision plans offered by the insurer or prepaid vision plan organization.

Added by Laws 1957, c. 261, § 1204, operative July 1, 1957. Amended by Laws 1965, c. 261, § 2, emerg. eff. June 22, 1965; Laws 1980, c. 196, § 1, eff. Oct. 1, 1980; Laws 1987, c. 210, § 34, eff. July 1, 1987; Laws 2005, c. 129, § 10, eff. Nov. 1, 2005; Laws 2006, c. 180, § 1, eff. Nov. 1, 2006; Laws 2007, c. 1, § 20, emerg. eff. Feb. 22, 2007; Laws 2012, c. 148, § 1, eff. Nov. 1, 2012; Laws 2024, c. 360, § 16, emerg. eff. May 30, 2024.

NOTE: Laws 2006, c. 264, § 43 repealed by Laws 2007, c. 1, § 21, emerg. eff. Feb. 22, 2007.

§36-1204.1. Availability of loss runs and claims histories.

Property and casualty insurers and advisory board or advisory organizations shall make loss runs or claims history available to current and former policyholders within thirty (30) days upon a written request by the policyholder.

Added by Laws 2007, c. 125, § 8, eff. July 1, 2007. Amended by Laws 2010, c. 222, § 23, eff. Nov. 1, 2010.

§36-1205. Power of commissioner.

The Commissioner shall have power to examine and investigate into the affairs of every person engaged in the business of insurance in this state in order to determine whether such person has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice prohibited by Section 1203 of this article.

Laws 1957, p. 263, § 1205.

§36-1206. Statement of charges and notice of hearing - Opportunity to be heard.

A. Whenever the Insurance Commissioner shall have reason to believe that any person has been engaged or is engaging in this state in any unfair method of competition or any unfair or deceptive act or practice defined in Section 1204 of this title, and that a

proceeding by the Commissioner in respect thereto would be to the interest of the public, the Commissioner shall issue and serve upon the person a statement of the charges in that respect and a notice in accordance with the Administrative Procedures Act.

B. At the time and place fixed for a hearing, the person shall have an opportunity to be heard and to show cause why an order should not be made by the Commissioner requiring the person to cease and desist from the acts, methods or practices so complained of. Upon good cause shown, the Commissioner shall permit any person to intervene, appear and be heard at the hearing by counsel or in person.

Added by Laws 1957, p. 263, § 1206. Amended by Laws 1997, c. 418, § 43, eff. Nov. 1, 1997.

§36-1207. Cease and desist orders and modifications thereof.

A. If, after a hearing or waiver of the right to a hearing, the Insurance Commissioner shall determine that the method of competition or the act or practice in question is defined in Section 1204 of this title and that the person complained of has engaged in a method of competition, act or practice in violation of this article, the Commissioner shall reduce these findings to writing and shall issue and cause to be served upon the person charged with the violation an order requiring the person to cease and desist from engaging in such method of competition, act or practice.

B. Until the expiration of the time allowed under subsection A of Section 1208 of this title for filing a petition for review, if no such petition has been duly filed within such time, or if a petition for review has been filed within such time, then until the transcript of the record in the proceeding has been filed in the court, as hereinafter provided, the Commissioner may at any time, upon such notice and in such manner as the Commissioner shall deem proper, modify or set aside in whole or in part any order issued by the Commissioner under this section.

C. After the expiration of the time allowed for filing a petition for review, if no petition has been duly filed within such time, the Commissioner may at any time, after notice and opportunity for hearing, reopen and later, modify or set aside, in whole or in part, any order issued by the Commissioner under this section whenever in the Commissioner's opinion conditions of fact or of law has so changed as to require such action or if the public interest shall so require.

Added by Laws 1957, p. 264, § 1207. Amended by Laws 1957, p. 264, § 1207; Laws 1997, c. 418, § 44, eff. Nov. 1, 1997.

§36-1208. Judicial review of cease and desist orders.

A. Any person required by an order of the Insurance Commissioner under Section 1207 of this title to cease and desist

from engaging in any unfair method of competition or any unfair or deceptive act or practice defined in Section 1204 of this title may obtain a review of such order by filing in the district court of Oklahoma County, or the county in which the order was served, within thirty (30) days from the date of service of such order, a written petition praying that the order of the Commissioner be set aside. A copy of the petition shall be served upon the Commissioner, and thereupon the Commissioner shall certify and file in such court a transcript of the entire record in the proceeding, including all the evidence taken and the report and order of the Commissioner. Upon filing the petition and transcript, the court shall have jurisdiction of the proceeding and of the question determined therein, shall determine whether the filing of the petition shall operate as a stay of the order of the Commissioner, and shall have power to make and enter upon the pleadings, evidence, and proceedings set forth in the transcript a decree modifying, affirming or reversing the order of the Commissioner, in whole or in part. The findings of the Commissioner as to the facts, if supported by the evidence, shall be conclusive.

B. To the extent that the order of the Commissioner is affirmed, the court shall thereupon issue its own order commanding obedience to the terms of the order of the Commissioner. If either party shall apply to the court for leave to adduce additional evidence, and shall show to the satisfaction of the court that additional evidence is material and that there were reasonable grounds for the failure to adduce such evidence in the proceeding before the Commissioner, the court may order additional evidence be taken before the Commissioner, and to be adduced upon the hearing in such manner and upon such terms and conditions as to the court may seem proper. The Commissioner may modify findings of fact, or make new findings by reason of the additional evidence so taken, and shall file such modified or new findings which, if supported by the evidence, shall be conclusive, and his recommendation, if any, for the modification or setting aside of his original order, with the return of such additional evidence. Appeal may be taken from the district court as provided in other civil cases.

C. A cease and desist order issued by the Commissioner under Section 1207 of this title shall become final:

1. Upon the expiration of the time allowed for filing a petition for review if no such petition has been duly filed within such time; except that the Commissioner may thereafter modify or set aside an order to the extent provided in subsection B of Section 1207 of this title; or

2. Upon the final decision of the court if the court directs that the order of the Commissioner be affirmed or the petition for review dismissed.

D. No order of the Commissioner under this article or order of a court to enforce the same shall in any way relieve or absolve any person affected by such order from any liability under any other laws of this state.

Added by Laws 1957, p. 265, § 1208. Amended by Laws 1997, c. 418, § 45, eff. Nov. 1, 1997.

§36-1209. Procedure as to unfair methods of competition and unfair or deceptive acts or practices which are not defined.

A. Whenever the Insurance Commissioner shall have reason to believe that any person engaged in the business of insurance is engaging in this state in any method of competition or in any act or practice in the conduct of such business which is not defined in Section 1204 of this title, that the method of competition is unfair or that the act or practice is unfair or deceptive and that an administrative proceeding in respect thereto would be to the interest of the public, the Commissioner may issue and serve such person a statement of the charges in that respect and a notice in accordance with the Administrative Procedures Act. The Commissioner shall, after a hearing or waiver of the right to a hearing, make a report in writing stating findings as to the facts and serve a copy thereof upon such person.

B. If such report charges a violation of this article and if such method of competition, act or practice has not been discontinued, the Commissioner may cause a petition to be filed in the district court of Oklahoma County or the district court of this state within the district wherein the person resides or has his or her principal place of business, to enjoin and restrain such person from engaging in such method, act or practice. The Commissioner may request the Attorney General to appear in the name of the state by relation of the Commissioner. The court shall have jurisdiction of the proceeding and shall have power to make and enter appropriate orders in connection therewith and to issue such writs as are ancillary to its jurisdiction or are necessary in its judgment to prevent injury to the public pendente lite.

C. A transcript of the proceedings before the Commissioner including all evidence taken and the report and findings shall be filed with such petition. If either party shall apply to the court for leave to adduce additional evidence and shall show, to the satisfaction of the court, that additional evidence is material and there were reasonable grounds for the failure to adduce evidence in the proceeding before the Commissioner, the court may order additional evidence to be taken before the Commissioner and to be adduced upon the hearing in such manner and upon such terms and conditions as to the court may seem proper. The Commissioner may modify findings of fact or make new findings by reason of the

additional evidence so taken, and he shall file such modified or new findings with the return of such additional evidence.

D. If the court finds that the method of competition complained of is unfair or that the act or practice complained of is unfair or deceptive, that the proceeding by the Commissioner with respect thereto is to the interest of the public and that the findings of the Commissioner are supported by the weight of the evidence, it shall issue its order enjoining and restraining the continuance of such method of competition, act or practice.

Added by Laws 1957, p. 265, § 1209. Amended by Laws 1997, c. 418, § 46, eff. Nov. 1, 1997.

§36-1210. Judicial review by intervenor.

If the final order of the Insurance Commissioner does not charge a violation of this article, then any intervenor in the proceedings may, within thirty (30) days after the service of such order, cause an action for judicial review to be filed in the district court of Oklahoma County for a review of such order. Upon such review, the court shall have authority to issue appropriate orders and decrees in connection therewith, including, if the court finds that it is to the interest of the public, orders enjoining and restraining the continuance of any method of competition, act or practice which it finds, notwithstanding such order of the Commissioner, constitutes a violation of this article.

Added by Laws 1957, p. 266, § 1210. Amended by Laws 1997, c. 418, § 47, eff. Nov. 1, 1997.

§36-1211. Civil penalty.

Any person who violates a cease and desist order of the Insurance Commissioner issued and served pursuant to the provisions of Section 1207 of this title, after it has become final, and while such order is in effect, shall, upon proof thereof to the satisfaction of the court, forfeit and pay to the State of Oklahoma a civil penalty of not less than One Hundred Dollars (\$100.00), nor more than One Thousand Dollars (\$1,000.00) for each violation.

Added by Laws 1957, p. 266, § 1211. Amended by Laws 1983, c. 68, § 10, eff. Nov. 1, 1983; Laws 1997, c. 418, § 48, eff. Nov. 1, 1997.

§36-1212. Provisions of act additional.

The powers vested in the Commissioner by this article shall be additional to any other powers to enforce penalties, fines or forfeitures authorized by law with respect to the methods, acts and practices hereby declared to be unfair or deceptive.

Laws 1957, p. 266, § 1212.

§36-1213. Immunity from prosecution.

If any person shall ask to be excused from attending and testifying or from producing any books, papers, records, correspondence or other documents at any hearing on the ground that the testimony or evidence required of the person may tend to incriminate the person or subject the person to a penalty or forfeiture, and shall notwithstanding be directed to give such testimony or produce such evidence, the person must nonetheless comply with such direction, but shall not thereafter be prosecuted or subjected to any criminal penalty of forfeiture for or on account of any evidence which the person may testify or produce pursuant thereto. No testimony so given or evidence produced shall be received against the person upon any criminal action, investigation or proceeding; provided, however, individuals so testifying shall not be exempt from prosecution or punishment for any perjury committed by them while so testifying and the testimony or evidence so given or produced shall be admissible against them upon any criminal action, investigation or proceeding concerning such perjury, and such individuals shall not be exempt from the refusal, revocation or suspension of any license, permission or authority conferred, or to be conferred, pursuant to the insurance law of this state.

Added by Laws 1957, p. 266, § 1213. Amended by Laws 1997, c. 418, § 49, eff. Nov. 1, 1997.

§36-1214. Fair disclosure - Protection against misleading sales methods.

The purpose of this act is to assure fair disclosure of relevant facts in the sale of life insurance and annuity contracts. This act is also designed to protect citizens of the State of Oklahoma as purchasers and prospective purchasers of life insurance policies or annuity contracts against the use of sales methods which are misleading because of:

1. The omission of facts fairly describing the subject matter as a life insurance policy or annuity contract and the benefits obtainable thereunder;
2. An undue emphasis upon facts which, even though correct, are not relevant to the sale of life insurance or annuities; or
3. An undue emphasis upon features which are of incidental or secondary importance to the life insurance aspects of a policy.

This act is deemed necessary for the effectuation of Section 1201 et seq., Title 36, Oklahoma Statutes, known as the Unfair Practices and Frauds Act; Section 1401 et seq., Title 36, Oklahoma Statutes; and Sections 2741 and 2742, Title 36, Oklahoma Statutes; and shall be construed as supplemental and cumulative to existing laws.

Laws 1972, c. 223, § 1, operative Jan. 15, 1974.

§36-1215. Definitions.

As used in this act, the following words, terms and phrases shall have the respective meanings hereinafter set forth, unless the context shall otherwise require:

1. A "coupon policy" is any policy or contract of life insurance, other than annuity, which contains, in addition to basic life insurance benefits, annual endowment benefits evidenced in the policy contract by coupons which mature as annual endowment benefits. For the purposes of this act, policies containing annual endowment benefits evidenced by coupons, passbooks or other devices generally identified with savings, banking or investment institutions shall be considered to be coupon policies;

2. A "profit-sharing policy" is that form of life insurance policy or annuity contract which contains provisions representing or tending to create the understanding that the policyholder will be eligible to participate in any future distribution of general corporate profits, with special advantage not available to persons holding other types of policies issued by the insurer to individuals of the same class and equal expectation of life; and

3. A "charter policy" or "founders policy" is that form of life insurance policy or annuity contract, usually issued by a newly-organized insurer, which is sold on the basis that its availability will be limited to a specific predetermined number of units of a fixed dollar amount and which generally provides that the policyholder shall participate in the earnings resulting from either the participating policies or the nonparticipating policies sold by the insurer, or both.

Laws 1972, c. 223, § 2, operative Jan. 15, 1974.

§36-1216. Prohibitions and regulations concerning use of certain types of policy forms, policy provisions and annuity contracts.

In accordance with the purpose expressed in Section 1 of this act, the use of certain types of policy forms, policy provisions and annuity contracts shall be subject to the following prohibitions and regulations:

1. No life insurance policy or annuity contract containing a series of guaranteed annual endowment benefits evidenced by coupons, passbooks or similar devices generally identified with investment or banking operations shall be approved for use, and no such policy or contract heretofore approved shall be issued or delivered in this state after January 15, 1974;

2. No life insurance policy or annuity contract containing a series of guaranteed annual endowment benefits shall be approved for use and no such policy or contract heretofore approved shall be issued or delivered in this state after January 15, 1974, unless the following requirements are satisfied:

a. the gross premium for the guaranteed annual endowment benefit shall be shown conspicuously and separately in the policy, distinct from the gross premium for the life insurance benefits and, unless the gross premium is so prominently and separately shown on the schedule of benefits and premiums page in the policy, the language shall be substantially in the following form: "The premium shown includes an additional (annual, semiannual, quarterly, monthly, etc.) premium of \$_____ for endowment benefits,"

b. the insured shall be entitled to withdraw the guaranteed annual endowment benefits not less frequently than at the end of each policy year. The number of one-year guaranteed endowment benefits shall equal the number of annual premiums for such benefits unless the insurance contract clearly and distinctly provides otherwise,

c. payment of any guaranteed annual endowment benefits shall not be made contingent on the payment of premiums falling due on or after the time the guaranteed annual endowment benefit has matured,

d. the separately stated gross premium for the series of guaranteed annual endowment benefits shall be based on reasonable assumptions, consistent with the basic policy form as to interest, mortality and expense,

e. the guaranteed annual endowment benefit shall be expressed in dollars, both in the policy and in any sales or advertising material relating thereto, and not as a percentage of any premium or benefit,

f. no guaranteed annual endowment benefit shall be described, either in the policy or in any sales or advertising material, as anything other than a guaranteed benefit for which a premium is being paid by the policyholder, and

g. at the time the policy form is filed with the Insurance Department for approval, said policy form shall be accompanied by all sales, advertising or other material which the insurer proposes to use in connection with the sale of such policy; such sales, advertising or other material shall be approved by the State Insurance Commissioner.

Nothing in this subsection shall apply to any policy in which the amount of any endowment or periodic benefit or benefits payable during any policy year is greater than the total annual premium for such year;

3. No coupon policy shall be approved or issued in this state after the effective date of this act, nor shall any coupon policy heretofore approved be issued or delivered in this state after January 15, 1974;

4. No profit-sharing policy shall be approved for use in this state after the effective date of this act, nor shall any profit-sharing policy heretofore approved be issued or delivered in this

state after January 15, 1974. Nothing contained in this section shall apply to variable annuity contracts to the extent that such are permitted under the laws of this state.

This subsection shall not be construed to restrict or prohibit the sale in this state of any participating life insurance policy where the dividend or abatement of premium is derived solely from the profits of that class of participating business;

5. No charter, founders or coupon policy or policy with a name of similar connotation shall be approved for use in this state after the effective date of this act and no charter, founders or coupon policy or policy with a name of similar connotation heretofore approved shall be issued or delivered in this state after January 15, 1974; and

6. No annual endowment shall be described as being a guaranteed dividend, nor as earnings on the premium investment. Nothing in this section shall be construed to prohibit a representation that a holder of a participating life insurance policy or annuity contract will participate in the share of the divisible surplus, if any, apportioned to the policy or contract by the insurer.

Laws 1972, c. 223, § 3, operative Jan. 15, 1974.

§36-1217. Prohibitions and regulations relating to insurers, agents of insurers, representatives of insurers and brokers - Group insurance and group annuity contracts exempt.

In accordance with the purpose expressed in Section 1 of this act, insurers, agents of insurers, representatives of insurers and brokers shall be subject to the following prohibitions and regulations:

1. No insurer, agent of an insurer or representative of an insurer shall deliver within this state, or issue for delivery within this state, any policy of life insurance or annuity contract which uses as its name or title a phrase which does not include the words, "Life Insurance" or "Annuity Contract" unless such phrase is accompanied by other language elsewhere in the policy or contract which indicates that it is a life insurance policy or annuity contract;

2. The use of the terms "Investment," "Investment Plan," "Expansion Plan," "Profit," "Profit-sharing" and similar terms in connection with a policy of life insurance or an annuity contract, in a context or under such circumstances or conditions as to have the capacity or tendency to mislead a purchaser or prospective purchaser of such policy or contract to believe that he will receive, or that it is possible that he will receive, something other than a life insurance policy or annuity contract or some benefit not provided in the policy or contract or some benefit not

available to other persons of the same class and equal expectation of life, is unlawful and is prohibited;

3. No insurer, agent or broker shall within this state:

a. make any statement or reference relating to the growth of the life insurance industry in connection with any solicitation of an application for life insurance or annuity contract in a context which could reasonably be understood to interest a prospect in the purchase of shares of stock in an insurer rather than in the purchase of a life insurance policy or annuity contract,

b. make any statement which reasonably gives rise to the inference that an insured or a prospective insured, by virtue of purchasing a policy of life insurance or an annuity contract, will enjoy a status common to a stockholder or will acquire a stock ownership interest in the insurer; provided, however, that nothing in this paragraph is intended to prohibit the practice of pointing out those aspects in which the status of a policyholder in a mutual life insurer is similar to that of a stockholder in a stock life insurer,

c. make any reference to or statement concerning an insurer's "Investment Department," "Insured Investment Department" or similar terminology, in such a manner as to imply that the policy was sold or issued by the investment department of the life insurer,

d. make any statement or reference which would reasonably tend to imply that, by purchasing a policy, the purchaser or prospective purchaser will become a member of a limited group of persons who may receive special advantages or favored treatment in the payment of dividends, unless such benefits are specifically provided in the insurance contract. This paragraph shall not apply to policies under which insured persons of one class of risk may receive dividends at a higher rate than persons of another class of risk,

e. state or imply that a particular kind of policy is available for only a limited time or that only a limited number of a particular kind of policy will be offered for sale or that only a limited number of persons, or a limited class of persons, will be eligible to buy a particular kind of policy, unless such limitation is specifically provided in the insurance contract,

f. state or imply that policyholders who are said to act as "centers of influence" or as an advisory board for an insurer will share, because of so acting, in the insurer's surplus earnings in some manner not available to other policyholders who are otherwise in the same class,

g. describe or refer to premium payments in language which states that the payment is a "deposit" unless:

(1) the payment sets up a debtor-creditor relationship between the life insurance company and the policyholder

and a showing is made as to when and how the deposit may be withdrawn,

(2) the term is used in conjunction with the word "premium" in such a manner as to indicate clearly the true character of the payment, or

(3) the term is used in connection with pension trust or deposit administration plans,

h. use the words "dividends," "cash dividends," "surplus" or similar phrases in such a manner as to state or imply that the payment of dividends is guaranteed or certain to occur,

i. state or imply that a purchaser of a policy will share in a stated percentage or portion of the earnings of the insurer. Nothing in this paragraph is intended to prohibit a representation that a holder of a participating life insurance policy or annuity contract will participate in the share of the divisible surplus, if any, apportioned to the policy or contract by the insurer,

j. make any statement or implication that dividends under a participating policy will be sufficient at any time to assure the receipt of benefits, such as a paid-up policy, without the further payment of premiums, unless the statement is accompanied by an adequate explanation as to what benefits or coverage would be provided at such time and the conditions under which this would occur,

k. state that the insured is guaranteed certain benefits if the policy is allowed to lapse without making an adequate explanation of the nonforfeiture benefits,

l. describe a life insurance policy or annuity contract or premium payments therefor in terms of "units of participation" unless accompanied by other language clearly indicating the reference to a life insurance policy or annuity contract or to premium payments, as the case may be,

m. include in sales kits and prepared sales presentations proposed answers to a prospect's questions as to whether life insurance policies or annuity contracts are being sold, which are designed to avoid a clear and unequivocal statement that life insurance or annuities are the subject matter of the solicitation,

n. display in any manner to a prospective policyholder any material which includes illustrations, using dollar amounts, in connection with the proposed sale of a life insurance or annuity contract unless the printed material clearly identifies that the subject, to which the dollar amounts pertain, has an economic relationship to guaranteed values and dividends of the policy,

o. make any general statement that an insurer makes a profit as a result of policy lapses or surrenders,

p. make comparisons to the past experience of other life insurers as a means of projecting possible experience of the soliciting insurer when those comparisons are designed to enhance the characteristics of the policy being sold by confining the comparisons to insurers having favorable experience with that type of policy without a fair disclosure of other insurers which have had unfavorable experience with such type of policy,

q. state that a policy contains certain features which are not found in other life insurance policies or annuity contracts, unless that be true,

r. represent an option to purchase insurance in the future in such a manner that the policyholder might reasonably infer that he is purchasing term insurance or some other form of life insurance that would result in a payment to the beneficiary in the event of the death of the policyholder, or

s. make any reference to a policy of life insurance or an annuity contract in such a manner as to misrepresent the true nature of the policy contract;

4. No insurer, agent for an insurer or representative for an insurer shall, as a competitive or "twisting" device, inform any policyholder or prospective policyholder that any other insurer is required to change a policy form or related material to comply with the provisions of this act; and

5. This section shall not apply to group insurance policies nor to group annuity contracts.

Laws 1972, c. 223, § 4, operative Jan. 15, 1974.

§36-1219. Clean claims - Reimbursement - Notice of defective claims - Interest on overdue payments - Attorney's fees.

A. In the administration, servicing, or processing of any accident and health insurance policy, every insurer shall reimburse all clean claims of an insured, an assignee of the insured, or a health care provider within forty-five (45) calendar days after receipt of a paper claim and thirty (30) calendar days after receipt of an electronic claim by the insurer.

B. As used in this section:

1. "Accident and health insurance policy" or "policy" means any policy, certificate, contract, agreement or other instrument that provides accident and health insurance, as defined in Section 703 of this title, to any person in this state, and any subscriber certificate or any evidence of coverage issued by a health maintenance organization to any person in this state;

2. "Clean claim" means a claim that has no defect or impropriety including a lack of any required substantiating documentation or particular circumstance requiring special treatment that impedes prompt payment; and

3. "Insurer" means any entity that provides an accident and health insurance policy in this state including, but not limited to, a licensed insurance company, a not-for-profit hospital service and medical indemnity corporation, a health maintenance organization, a fraternal benefit society, a multiple employer welfare arrangement, or any other entity subject to regulation by the Insurance Commissioner.

C. If a claim or any portion of a claim is determined to have defects or improprieties including a lack of any required substantiating documentation or particular circumstance requiring special treatment, the insured, enrollee or subscriber, assignee of the insured, enrollee or subscriber, and health care provider shall be notified in writing within thirty (30) calendar days after receipt of the claim by the insurer. The written notice shall specify the portion of the claim that is causing a delay in processing and explain any additional information or corrections needed. Failure of an insurer to provide the insured, enrollee or subscriber, assignee of the insured, enrollee or subscriber, and health care provider with the notice shall constitute prima facie evidence that the claim will be paid in accordance with the terms of the policy. Provided, if a claim is not submitted into the system due to a failure to meet basic Electronic Data Interchange (EDI) and/or Health Insurance Portability and Accountability Act (HIPAA) edits, electronic notification of the failure to the submitter shall be deemed compliance with this subsection. Provided further, health maintenance organizations shall not be required to notify the insured, enrollee or subscriber, or assignee of the insured, enrollee or subscriber of any claim defect or impropriety.

Upon receipt of the additional information or corrections which led to the claim's being delayed and a determination that the information is accurate, an insurer shall either pay or deny the claim or a portion of the claim within forty-five (45) calendar days for a paper claim and thirty (30) calendar days for an electronic claim.

D. If a clean claim or any portion of a clean claim is denied for any reason, the insured, enrollee or subscriber, assignee of the insured, enrollee or subscriber, and health care provider shall be notified in writing within thirty (30) calendar days after receipt of the claim by the insurer. The written notice shall specify in detail the reason for the denial including instructions on where a person or entity that received notification may respond through dedicated facsimile or electronic mail message or the address or electronic mail message address of the department of appeals of the insurer. Upon receiving written notice of denial, a recipient may submit a detailed appeal in writing explaining why the claim should be approved. If the insurer denies the appeal, the insurer shall address in writing the specific details included in the written

appeal and provide the phone number of a health plan representative at the department of appeals of the insurer.

E. Payment shall be considered made on:

1. The date a draft or other valid instrument which is equivalent to the amount of the payment is placed in the United States mail in a properly addressed, postpaid envelope; or

2. If not so posted, the date of delivery.

F. An overdue payment shall bear simple interest at the rate of ten percent (10%) per year.

G. In the event litigation should ensue based upon such a claim, the prevailing party shall be entitled to recover a reasonable attorney fee to be set by the court and taxed as costs against the party or parties who do not prevail.

H. The Insurance Commissioner shall develop a standardized prompt pay form for use by providers in reporting violations of prompt pay requirements. The form shall include a requirement that documentation of the reason for the delay in payment or documentation of proof of payment must be provided within ten (10) days of the filing of the form. The Commissioner shall provide the form to health maintenance organizations and providers.

I. The provisions of this section shall not apply to the Oklahoma Life and Health Insurance Guaranty Association or to the Oklahoma Property and Casualty Insurance Guaranty Association. Added by Laws 1975, c. 301, § 1, eff. Oct. 1, 1975. Amended by Laws 1986, c. 251, § 12, eff. Nov. 1, 1986; Laws 1987, c. 175, § 8, eff. Nov. 1, 1987; Laws 1992, c. 74, § 1, eff. Sept. 1, 1992; Laws 1997, c. 156, § 1, eff. Nov. 1, 1997; Laws 1997, c. 418, § 50, eff. Nov. 1, 1997; Laws 2001, c. 65, § 1, eff. Nov. 1, 2001; Laws 2003, c. 197, § 52, eff. Nov. 1, 2003; Laws 2007, c. 338, § 2, eff. July 1, 2007; Laws 2021, c. 200, § 1, eff. Nov. 1, 2021; Laws 2021, c. 478, § 6, emerg. eff. May 12, 2021.

§36-1219.1. Short title.

Sections 4 through 6 of this act shall be known and may be cited as the "Health Care Fraud Prevention Act".

Added by Laws 2000, c. 353, § 4, eff. Nov. 1, 2000.

§36-1219.2. Definitions.

As used in the Health Care Fraud Prevention Act:

1. "Accident and health insurance policy" means any policy, certificate, contract, agreement or other instrument that provides accident and health insurance, as defined in Section 703 of this title, to any person in this state;

2. "Health care provider" means a physician, hospital, ambulatory surgical center, pharmacy, pharmacist, laboratory, or any other state-licensed or state-recognized provider of health care services;

3. "Insured" means any person entitled to reimbursement for expenses of health care services and procedures under an accident and health insurance policy issued by an insurer;

4. "Insurer" means any entity that provides an accident and health insurance policy in this state, including but not limited to a licensed insurance company, a not-for-profit hospital service and medical indemnity corporation, a fraternal benefit society, a multiple employer welfare arrangement, or any other entity subject to regulation by the Insurance Commissioner;

5. "Preferred provider organization" means any entity defined as a "preferred provider organization (PPO)" in Section 6054 of this title; and

6. "Third-party administrator" means any person defined as an "administrator" in Section 1442 of this title.

Added by Laws 2000, c. 353, § 5, eff. Nov. 1, 2000.

§36-1219.3. Discounted reimbursement and disclosure of reimbursement terms prohibited.

A. An insurer or third-party administrator shall not reimburse a health care provider on a discounted fee basis for covered services that are provided to an insured unless:

1. The insurer or third-party administrator has contracted with either:

a. the health care provider, or

b. a preferred provider organization which has contracted with the health care provider;

2. The health care provider has agreed to provide health care services under the terms of the contract; and

3. The insurer or third-party administrator has agreed to provide coverage for those health care services under an accident and health insurance policy.

B. A party to a preferred provider contract, including a contract with a preferred provider organization, may not sell, lease, or otherwise transfer information regarding the payment or reimbursement terms of the contract without the express authority and prior adequate notification of the other contracting parties.
Added by Laws 2000, c. 353, § 6, eff. Nov. 1, 2000.

§36-1219.4. Definitions - Requirements for discount medical plan organizations - Penalties.

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 or be licensed by the Insurance Department 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 an application on the form that the Insurance Commissioner requires, and
- b. pay to the Insurance 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 Insurance Department a renewal application on the form that the Insurance Commissioner requires, and
- c. pays to the Insurance 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, 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 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.
- 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 Insurance Department may examine or investigate the business and affairs of any discount medical plan organization. The Insurance 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. All work papers, recorded information, documents, books, files, advertising and solicitation materials, copies or other information produced by, obtained by or disclosed to the Commissioner or any other person in the course of an examination or investigation made pursuant to this section or in the course of analysis by the Commissioner or other person, shall be given confidential treatment by the Commissioner and may not be made public by the Commissioner or any other person who obtained the information in the course of the examination or investigation, except to the extent provided in this section. Access may be

granted to the National Association of Insurance Commissioners. The parties shall agree in writing prior to receiving the information to provide to it the same confidential treatment as required by this section, unless the prior written consent of the company to which it pertains has been obtained. The confidentiality and protection from discovery by subpoena provided for in this paragraph shall not be construed to be extended to identical, similar or other related documents or information or to the work papers that are not deemed to be in the possession, custody or control of the Commissioner.

3. 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 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 subsection G of this section, shall first be filed with the Insurance 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 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 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 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 has cause to believe that grounds for the suspension or revocation of a registration exist, the Insurance 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 certificate of registration of a discount medical plan organization is nonrenewed, surrendered or revoked, such organization shall proceed, immediately following the effective date of the order of revocation, or in the case of nonrenewal, the date of expiration of the certificate of registration, 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 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 Insurance Department prior to the expiration of the suspension period. Reinstatement may not be made unless requested by the discount medical plan organization; however, the Insurance 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 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, having at all times a value of not less than Thirty-five Thousand Dollars (\$35,000.00), for use by the Insurance Department in protecting plan members.

2. No judgment creditor or other claimant of a discount medical plan organization, other than the Insurance Department, 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 Insurance 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.

Added by Laws 2001, c. 363, § 11, eff. July 1, 2001. Amended by Laws 2002, c. 307, § 12, eff. Nov. 1, 2002; Laws 2005, c. 425, § 1, eff. Nov. 1, 2005; Laws 2007, c. 125, § 9, eff. July 1, 2007; Laws 2009, c. 176, § 23, eff. Nov. 1, 2009; Laws 2010, c. 356, § 4, eff. Nov. 1, 2010; Laws 2012, c. 149, § 2, eff. Nov. 1, 2012.

§36-1219.5. Modification of existing or issuance of new coverage - Consent.

No insurer shall modify a group or individual policy of existing coverage or issue new coverage under an accident and health insurance policy unless written consent for such modification or issuance is obtained from the policyholder. However, this section shall not be construed as prohibiting a modification that is provided for in an existing policy that has been filed and approved by the Insurance Commissioner.

Added by Laws 2003, c. 288, § 1, eff. Nov. 1, 2003.

§36-1219.6. Methods of payments to providers - Prohibition on restricting methods - Notice of fees.

A. As used in this section:

1. "Health maintenance organization" means an entity that is organized for the purpose of providing or arranging health care, which has been granted a certificate of authority by the Insurance Commissioner as a health maintenance organization pursuant to the Health Maintenance Organization Act of 2003;

2. "Credit card payment" means a type of electronic funds transfer in which a health insurance plan or health insurer or its

contracted vendor issues a single-use series of numbers associated with the payment of health care services performed by a health care provider and chargeable to a predetermined dollar amount, whereby the health care provider is responsible for processing the payment by a credit card terminal or Internet portal. Such term shall include virtual or online credit card payments, whereby no physical credit card is presented to the health care provider and the single-use credit card expires upon payment processing;

3. "Electronic funds transfer payment" means a payment by any method of electronic funds transfer other than through the Automated Clearing House Network (ACH), as codified in 45 CFR Sections 162.1601 and 162.1602;

4. "Health care provider" means any physician, dentist, pharmacist, optometrist, psychologist, registered optician, licensed professional counselor, physical therapist, chiropractor, hospital or other entity or person that is licensed or otherwise authorized in this state to furnish health care services;

5. "Health care provider agent" means a person or entity that contracts with a health care provider establishing an agency relationship to process bills for services provided by the health care provider under the terms and conditions of a contract between the agent and health care provider. Such contracts may permit the agent to submit bills, request reconsideration and receive reimbursement;

6. "Health care services" means the examination or treatment of persons for the prevention of illness or the correction or treatment of any physical or mental condition resulting from illness, injury or other human physical problem and includes, but is not limited to:

- a. hospital services which include the general and usual services and care, supplies and equipment furnished by hospitals,
- b. medical services which include the general and usual services and care rendered and administered by doctors of medicine, doctors of dental surgery and doctors of podiatry, and
- c. other health care services which include appliances and supplies; nursing care by a registered nurse or a licensed practical nurse; care furnished by such other licensed practitioners; institutional services including the general and usual care, services, supplies and equipment furnished by health care institutions and agencies or entities other than hospitals; physiotherapy; ambulance services; drugs and medications; therapeutic services and equipment including oxygen and the rental of oxygen equipment; hospital beds; iron lungs; orthopedic services and appliances including wheelchairs, trusses, braces,

crutches and prosthetic devices including artificial limbs and eyes; and any other appliance, supply or service related to health care;

7. "Health insurance plan" means any hospital or medical insurance policy or certificate; qualified higher deductible health plan; health maintenance organization subscriber contract; contract providing benefits for dental care whether such contract is pursuant to a medical insurance policy or certificate; stand-alone dental plan, health maintenance provider contract or managed health care plan; and

8. "Health insurer" means any entity or person that issues health insurance plans, as defined in this section.

B. Any health insurance plan issued, amended or renewed on or after January 1, 2020, between a health insurer or its contracted vendor or a health maintenance organization and a health care provider for the provision of health care services to a plan enrollee shall not contain restrictions on methods of payment from the health insurer or its vendor or the health maintenance organization to the health care provider in which the only acceptable payment method is a credit card payment.

C. If initiating or changing payments to a health care provider using electronic funds transfer payments, including virtual credit card payments, a health insurance plan, health insurer or its contracted vendor or health maintenance organization shall:

1. Notify the health care provider if any fees are associated with a particular payment method; and

2. Advise the provider of the available methods of payment and provide clear instructions to the health care provider as to how to select an alternative payment method.

D. A health insurance plan, health insurer or its contracted vendor or health maintenance organization that initiates or changes payments to a health care provider through the Automated Clearing House Network, as codified in 45 CFR Sections 162.1601 and 162.1602, shall not charge a fee solely to transmit the payment to a health care provider unless the health care provider has consented to the fee. A health care provider agent may charge reasonable fees when transmitting an Automated Clearing House Network payment related to transaction management, data management, portal services and other value-added services in addition to the bank transmittal.

E. The provisions of this section shall not be waived by contract, and any contractual clause in conflict with the provisions of this section or that purport to waive any requirements of this section are void.

F. Violations of this section shall be subject to enforcement by the Insurance Commissioner.

Added by Laws 2019, c. 385, § 1, eff. Nov. 1, 2019.

§36-1220. Exclusive agents - Restrictions.

No insurance company, including any subsidiary of any such company, may offer any insurance program in this state to exclusive agents without offering the same insurance program through all of its other authorized agents and brokers authorized for similar types of insurance coverage.

Added by Laws 1985, c. 328, § 9, emerg. eff. July 29, 1985.

§36-1221. Renumbered as § 1250.1 of this title by Laws 1994, c. 342, § 20, eff. Sept. 1, 1994.

§36-1222. Repealed by Laws 1994, c. 342, § 21, eff. Sept. 1, 1994.

§36-1223. Renumbered as § 1250.9 of this title by Laws 1994, c. 342, § 20, eff. Sept. 1, 1994.

§36-1224. Renumbered as § 1250.10 of this title by Laws 1994, c. 342, § 20, eff. Sept. 1, 1994.

§36-1225. Renumbered as § 1250.11 of this title by Laws 1994, c. 342, § 20, eff. Sept. 1, 1994.

§36-1226. Renumbered as § 1250.13 of this title by Laws 1994, c. 342, § 20, eff. Sept. 1, 1994.

§36-1227. Renumbered as § 1250.3 of this title by Laws 1994, c. 342, § 20, eff. Sept. 1, 1994.

§36-1228. Repealed by Laws 1994, c. 342, § 21, eff. Sept. 1, 1994.

§36-1241. Property and casualty insurer - Acceptance or denial of application.

A property and casualty insurer shall, within forty-five (45) business days of taking an application, determine whether or not the applicant should be accepted or denied as an insured and shall give written notice to the agent of the acceptance or denial. If the applicant is denied as an insured, any premium monies paid, less any expenses incurred either by the agent or the insurer, shall be immediately returned to the proposed purchaser of the policy.

Failure of the insurer to return premium monies to the applicant within forty-five (45) business days of the initial submission to the insurer, broker, or agent, shall result in the applicant recovering any interest and bank charges which the proposed insured has incurred because of the delay in return of the initial premium, less expenses incurred. In addition, if the insurer does not return the premium monies, less expenses, within the forty-five-day period, the insurer shall remain liable for the insurance coverage and any

claims pursuant thereto which the remaining premium monies would have purchased.

Added by Laws 1986, c. 251, § 23, eff. Nov. 1, 1986. Amended by Laws 1987, c. 175, § 9, eff. Nov. 1, 1987; Laws 2000, c. 353, § 8, eff. Nov. 1, 2000; Laws 2001, c. 363, § 12, eff. July 1, 2001.

§36-1241.1. Property and casualty policies - Provision relating to process for premium refund for cancellation prior to end of policy period.

Each property and casualty insurance policy approved by the Insurance Commissioner shall contain a provision describing the process for premium refund if the insured cancels the policy before the end of the policy period as defined in the policy. The provision is to be included in the policy, or by rider or endorsement attached to the policy. The policy does not have to contain the exact wording of this section or any other exact wording. Language which is substantially similar to this section shall be considered to be in compliance with this section.

Added by Laws 2004, c. 96, § 3, eff. Nov. 1, 2004.

§36-1241.2. Property and casualty policies - Inquiry regarding making claim - Increase of premium rates, cancellation, or refusal to issue or renew policy.

No insurer that issues any type of property or casualty insurance policy in this state shall increase premium rates, cancel a policy, or refuse to issue or renew a policy solely on the basis of a policyholder inquiring about making a claim or requesting information about a possible claim, if the policyholder does not in fact submit a claim.

Added by Laws 2004, c. 96, § 4, eff. Nov. 1, 2004.

§36-1250.1. Short title.

Sections 1250.1 through 1250.16 of this title shall constitute a part of the Oklahoma Insurance Code and shall be known and may be cited as the "Unfair Claims Settlement Practices Act".

Added by Laws 1986, c. 315, § 5, emerg. eff. June 24, 1986. Amended by Laws 1994, c. 342, § 1, eff. Sept. 1, 1994. Renumbered from § 1221 of this title by Laws 1994, c. 342, § 20, eff. Sept. 1, 1994. Amended by Laws 1997, c. 5, § 1, emerg. eff. March 25, 1997.

§36-1250.2. Definitions.

As used in the Unfair Claims Settlement Practices Act:

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

2. "Claimant" means either a first party claimant, a third party claimant, or both, and includes such claimant's designated

legal representatives and includes a member of the claimant's immediate family designated by the claimant;

3. "Commissioner" means the Insurance Commissioner;

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

5. "Health benefit plan" means group hospital or medical insurance coverage, a not-for-profit hospital or medical service or indemnity plan, a prepaid health plan, a health maintenance organization plan, a preferred provider organization plan, the State and Education Employees Group Health Insurance Plan, and coverage provided by a Multiple Employer Welfare Arrangement (MEWA) or employee self-insured plan except as exempt under federal ERISA provisions. The term shall not include short-term accident, fixed indemnity, or specified disease policies, disability income contracts, limited benefit or credit disability insurance, workers' compensation insurance coverage, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and which is required by law to be contained in any liability insurance policy or equivalent self-insurance;

6. "Insurance policy or insurance contract" means any contract of insurance, certificate, indemnity, medical or hospital service, suretyship, annuity, subscriber certificate or any evidence of coverage of a health maintenance organization issued, proposed for issuance, or intended for issuance by any entity subject to this Code;

7. "Insurer" means a person licensed by the Commissioner to issue or who issues any insurance policy or insurance contract in this state and also includes health maintenance organizations. Provided that, for the purposes of paragraphs 15 and 16 of Section 1250.5 of this title, "insurer" shall include the State and Education Employees Group Insurance Board;

8. "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;

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

10. "Preauthorization/precertification" means a determination by a health benefit plan, based on the information presented at the time by the health care provider, that health care services proposed by the health care provider are medically necessary. The term shall

include "authorization", "certification" and any other term that would be a reliable determination by a health benefit plan. A preauthorization/precertification from a previous health plan shall not bind a succeeding health benefit plan;

11. "Third-party claimant" means any individual, corporation, association, partnership, or other legal entity asserting a claim against any individual, corporation, association, partnership, or other legal entity insured under an insurance policy or insurance contract; and

12. "Verification of eligibility" means a representation by a health benefit plan to a health care provider that a claimant is entitled to covered benefits under the policy. Such verification of eligibility shall be valid for four (4) business days from the date given by the health benefit plan.

Added by Laws 1986, c. 251, § 14, eff. Nov. 1, 1986. Amended by Laws 1994, c. 342, § 2, eff. Sept. 1, 1994. Renumbered from § 1252 of this title by Laws 1994, c. 342, § 20, eff. Sept. 1, 1994. Amended by Laws 1994, 2nd Ex. Sess., c. 1, § 4, emerg. eff. Nov. 4, 1994; Laws 2003, c. 197, § 53, eff. Nov. 1, 2003; Laws 2004, c. 274, § 7, eff. July 1, 2004; Laws 2005, c. 170, § 1, eff. Nov. 1, 2005; Laws 2009, c. 323, § 1, eff. July 1, 2010; Laws 2013, c. 254, § 19, eff. Jan. 1, 2015.

§36-1250.3. Application of law; conditions under which acts constitute unfair claims settlement practices.

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

B. It is an unfair claim settlement practice for any insurer to commit any act set out in Section 1250.5 of this title, or to commit a violation of any other provision of the Unfair Claims Settlement Practices Act, if:

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

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

Added by Laws 1986, c. 315, § 11, emerg. eff. June 24, 1986. Amended by Laws 1992, c. 74, § 4, eff. Sept. 1, 1992; Laws 1994, c. 342, § 3, eff. Sept. 1, 1994. Renumbered from § 1227 of this title by Laws 1994, c. 342, § 20, eff. Sept. 1, 1994. Amended by Laws 1997, c. 5, § 2, emerg. eff. March 25, 1997.

§36-1250.4. Claim files - Examination - Response to inquiries.

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

can be reconstructed. In addition, the Insurance Commissioner, authorized employees and examiners shall have access to any of an insurer's files that may relate to a particular complaint under investigation or to an inquiry or examination by the Insurance Department.

B. Any person subject to the jurisdiction of the Commissioner, upon receipt of any inquiry from the Commissioner shall, within twenty (20) calendar days from the date of receipt of the inquiry, furnish the Commissioner with an adequate response to the inquiry. The Commissioner may, upon good cause shown and on a case-by-case basis, extend the time allowed for a response for up to seven (7) additional calendar days. Any inquiry or response subject to this subsection shall be delivered electronically.

C. Every insurer, upon receipt of any pertinent written communication including but not limited to e-mail or other forms of written electronic communication, or documentation by the insurer of a verbal communication from a claimant which reasonably suggests that a response is expected, shall, within thirty (30) days after receipt thereof, furnish the claimant with an adequate response to the communication.

D. Any violation by an insurer of this section shall subject the insurer to discipline including a civil penalty of not less than One Hundred Dollars (\$100.00) nor more than Five Thousand Dollars (\$5,000.00).

Added by Laws 1986, c. 251, § 15, eff. Nov. 1, 1986. Amended by Laws 1989, c. 181, § 1, eff. Nov. 1, 1989; Laws 1994, c. 342, § 4, eff. Sept. 1, 1994. Renumbered from § 1253 of this title by Laws 1994, c. 342, § 20, eff. Sept. 1, 1994. Amended by Laws 1994, 2nd Ex. Sess., c. 1, § 5, emerg. eff. Nov. 4, 1994; Laws 1997, c. 418, § 51, eff. Nov. 1, 1997; Laws 2010, c. 222, § 24, eff. Nov. 1, 2010; Laws 2013, c. 254, § 20, eff. Jan. 1, 2015; Laws 2018, c. 95, § 4, eff. Nov. 1, 2018; Laws 2019, c. 294, § 1, eff. Nov. 1, 2019.

§36-1250.5. Acts by an insurer constituting an unfair claim settlement practice.

Any of the following acts by an insurer, if committed in violation of Section 1250.3 of this title, constitutes an unfair claim settlement practice exclusive of paragraph 16 of this section which shall be applicable solely to health benefit plans:

1. Failing to fully disclose to first-party claimants, benefits, coverages, or other provisions of any insurance policy or insurance contract when the benefits, coverages or other provisions are pertinent to a claim;

2. Knowingly misrepresenting to claimants pertinent facts or policy provisions relating to coverages at issue;

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

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

5. Failing to comply with the provisions of Section 1219 of this title;

6. Denying a claim for failure to exhibit the property without proof of demand and unfounded refusal by a claimant to do so;

7. Except where there is a time limit specified in the policy, making statements, written or otherwise, which require a claimant to give written notice of loss or proof of loss within a specified time limit and which seek to relieve the company of its obligations if the time limit is not complied with unless the failure to comply with the time limit prejudices the rights of an insurer. Any policy that specifies a time limit covering damage to a roof due to wind or hail must allow the filing of claims after the first anniversary but no later than twenty-four (24) months after the date of the loss, if the damage is not evident without inspection;

8. Requesting a claimant to sign a release that extends beyond the subject matter that gave rise to the claim payment;

9. Issuing checks, drafts or electronic payment in partial settlement of a loss or claim under a specified coverage which contain language releasing an insurer or its insured from its total liability;

10. Denying payment to a claimant on the grounds that services, procedures, or supplies provided by a treating physician, hospital, or person or entity licensed or otherwise authorized to provide health care services were not medically necessary unless the health insurer or administrator, as defined in Section 1442 of this title, first obtains an opinion from any provider of health care licensed by law and preceded by a medical examination or claim review, to the effect that the services, procedures or supplies for which payment is being denied were not medically necessary. In the event that claims for mental health or substance use disorder treatments and services are under review, the reviewing health care provider shall have appropriate, qualified, and specialized credentials with respect to the services and treatments. Upon written request of a claimant, treating physician, hospital, or authorized person or entity, the opinion shall be set forth in a written report, prepared and signed by the reviewing physician. The report shall detail which specific services, procedures, or supplies were not medically necessary, in the opinion of the reviewing physician, and an explanation of that conclusion. A copy of each report of a reviewing physician shall be mailed by the health insurer, or administrator, postage prepaid, to the claimant, treating physician,

hospital, or authorized person or entity requesting same within fifteen (15) days after receipt of the written request. As used in this paragraph, "physician" means a person holding a valid license to practice medicine and surgery, osteopathic medicine, podiatric medicine, dentistry, chiropractic, or optometry, pursuant to the state licensing provisions of Title 59 of the Oklahoma Statutes;

11. Compensating a reviewing physician, as defined in paragraph 10 of this section, on the basis of a percentage of the amount by which a claim is reduced for payment;

12. Violating the provisions of the Health Care Fraud Prevention Act;

13. Compelling, without just cause, policyholders to institute suits to recover amounts due under its insurance policies or insurance contracts by offering substantially less than the amounts ultimately recovered in suits brought by them, when the policyholders have made claims for amounts reasonably similar to the amounts ultimately recovered;

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

15. Requesting a refund of all or a portion of a payment of a claim made to a claimant more than twelve (12) months or a health care provider more than eighteen (18) months after the payment is made. This paragraph shall not apply:

- a. if the payment was made because of fraud committed by the claimant or health care provider, or
- b. if the claimant or health care provider has otherwise agreed to make a refund to the insurer for overpayment of a claim;

16. Failing to pay, or requesting a refund of a payment, for health care services covered under the policy if a health benefit plan, or its agent, has provided a preauthorization or precertification and verification of eligibility for those health care services. This paragraph shall not apply if:

- a. the claim or payment was made because of fraud committed by the claimant or health care provider,
- b. the subscriber had a preexisting exclusion under the policy related to the service provided, or
- c. the subscriber or employer failed to pay the applicable premium and all grace periods and extensions of coverage have expired;

17. Denying or refusing to accept an application for life insurance, or refusing to renew, cancel, restrict or otherwise terminate a policy of life insurance, or charge a different rate based upon the lawful travel destination of an applicant or insured as provided in Section 4024 of this title; or

18. As a health insurer that provides pharmacy benefits or a pharmacy benefits manager that administers pharmacy benefits for a health plan, failing to include any amount paid by an enrollee or on behalf of an enrollee by another person when calculating the enrollee's total contribution to an out-of-pocket maximum, deductible, copayment, coinsurance or other cost-sharing requirement.

However, if, under federal law, application of this paragraph would result in health savings account ineligibility under Section 223 of the federal Internal Revenue Code, as amended, this requirement shall apply only for health savings accounts with qualified high-deductible health plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible, except with respect to items or services that are preventive care pursuant to Section 223(c)(2)(C) of the federal Internal Revenue Code, as amended, in which case the requirements of this paragraph shall apply regardless of whether the minimum deductible has been satisfied.

Added by Laws 1986, c. 251, § 16, eff. Nov. 1, 1986. Amended by Laws 1989, c. 238, § 1, eff. Nov. 1, 1989; Laws 1991, c. 134, § 9, eff. July 1, 1991; Laws 1993, c. 24, § 1, eff. Sept. 1, 1993; Laws 1994, c. 342, § 5, eff. Sept. 1, 1994. Renumbered from § 1254 of this title by Laws 1994, c. 342, § 20, eff. Sept. 1, 1994. Amended by Laws 1997, c. 156, § 2, eff. Nov. 1, 1997; Laws 1997, c. 404, § 3, eff. Nov. 1, 1997; Laws 1997, c. 418, § 52, eff. Nov. 1, 1997; Laws 1999, c. 256, § 1, eff. Nov. 1, 1999; Laws 2000, c. 353, § 7, eff. Nov. 1, 2000; Laws 2009, c. 323, § 2, eff. July 1, 2010; Laws 2012, c. 105, § 1; Laws 2021, c. 37, § 1, eff. Nov. 1, 2021; Laws 2021, c. 478, § 7, emerg. eff. May 12, 2021; Laws 2022, c. 266, § 1, emerg. eff. May 16, 2022; Laws 2023, c. 214, § 1, eff. Nov. 1, 2023. NOTE: Laws 1997, c. 5, § 3 repealed by Laws 1997, c. 404, § 8, eff. Nov. 1, 1997.

§36-1250.6. Property and casualty insurer - Acknowledging receipt of claim - Commissioner's inquiry - Other communications - Claim forms, instructions and assistance.

A. Every property and casualty insurer, within thirty (30) days after receiving notification of a claim, shall acknowledge the receipt of such notification unless payment is made within such period of time. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgement shall be made in the claim file of the property and casualty insurer, and

dated. Notification given to an agent of a property and casualty insurer shall be notification to the insurer.

B. Every property and casualty insurer, upon receiving notification of a claim, promptly shall provide necessary claim forms, instruction, and reasonable assistance so that first party claimants can comply with the policy conditions and the reasonable requirements of the property and casualty insurer. Compliance with this paragraph within thirty (30) days after notification of a claim shall constitute compliance with subsection A of this section. Added by Laws 1986, c. 251, § 17, eff. Nov. 1, 1986. Amended by Laws 1987, c. 175, § 10, eff. Nov. 1, 1987; Laws 1994, c. 342, § 6, eff. Sept. 1, 1994. Renumbered from § 1255 of this title by Laws 1994, c. 342, § 20, eff. Sept. 1, 1994; Laws 1997, c. 418, § 53, eff. Nov. 1, 1997.

§36-1250.7. Property and casualty insurer - Denial or acceptance of claim.

A. Within sixty (60) days after receipt by a property and casualty insurer of properly executed proofs of loss, the first party claimant shall be advised of the acceptance or denial of the claim by the insurer, or if further investigation is necessary. No property and casualty insurer shall deny a claim because of a specific policy provision, condition, or exclusion unless reference to such provision, condition, or exclusion is included in the denial. A denial shall be given to any claimant in writing, and the claim file of the property and casualty insurer shall contain a copy of the denial. If there is a reasonable basis supported by specific information available for review by the Commissioner that the first party claimant has fraudulently caused or contributed to the loss, a property and casualty insurer shall be relieved from the requirements of this subsection. In the event of a weather-related catastrophe or a major natural disaster, as declared by the Governor, the Insurance Commissioner may extend the deadline imposed under this subsection an additional twenty (20) days.

B. If a claim is denied for reasons other than those described in subsection A of this section, and is made by any other means than writing, an appropriate notation shall be made in the claim file of the property and casualty insurer until such time as a written confirmation can be made.

C. Every property and casualty insurer shall complete investigation of a claim within sixty (60) days after notification of proof of loss unless such investigation cannot reasonably be completed within such time. If such investigation cannot be completed, or if a property and casualty insurer needs more time to determine whether a claim should be accepted or denied, it shall so notify the claimant within sixty (60) days after receipt of the proofs of loss, giving reasons why more time is needed. If the

investigation remains incomplete, a property and casualty insurer shall, within sixty (60) days from the date of the initial notification, send to such claimant a letter setting forth the reasons additional time is needed for investigation. Except for an investigation of possible fraud or arson which is supported by specific information giving a reasonable basis for the investigation, the time for investigation shall not exceed one hundred twenty (120) days after receipt of proof of loss. Provided, in the event of a weather-related catastrophe or a major natural disaster, as declared by the Governor, the Insurance Commissioner may extend this deadline for investigation an additional twenty (20) days.

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

E. Insurers shall not continue or delay negotiations for settlement of a claim directly with a claimant who is neither an attorney nor represented by an attorney, for a length of time which causes the claimant's rights to be affected by a statute of limitations, or a policy or contract time limit, without giving the claimant written notice that the time limit is expiring and may affect the claimant's rights. Such notice shall be given to first party claimants and third party claimants one year after the date of the loss.

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

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

Added by Laws 1986, c. 251, § 18, eff. Nov. 1, 1986. Amended by Laws 1987, c. 175, § 11, eff. Nov. 1, 1987; Laws 1993, c. 248, § 1, eff. Sept. 1, 1993; Laws 1994, c. 342, § 7, eff. Sept. 1, 1994. Renumbered from § 1256 of this title by Laws 1994, c. 342, § 20, eff. Sept. 1, 1994. Amended by Laws 1997, c. 418, § 54, eff. Nov. 1, 1997; Laws 2018, c. 95, § 7, eff. Nov. 1, 2018; Laws 2021, c. 478, § 8, emerg. eff. May 12, 2021.

§36-1250.8. Motor vehicle total loss or damage claim.

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

1. An insurer may elect to offer a replacement motor vehicle which is a specific comparable motor vehicle available to the

insured, with all applicable taxes, license fees, and other fees incident to the transfer of evidence of ownership of the motor vehicle paid, at no cost to the insured other than any deductible provided in the policy. The offer and any rejection thereof shall be documented in the claim file; or

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

- a. the cost of a comparable motor vehicle in the local market area when a comparable motor vehicle is currently or recently available in the prior ninety (90) days in the local market area,
- b. one of two or more quotations obtained by an insurer from two or more qualified dealers located within the local market area when a comparable motor vehicle is not available in the local market area, or
- c. the cost of a comparable motor vehicle as quoted in the latest edition of the National Automobile Dealers Association Official Used Car Guide or monthly edition of any other nationally recognized published guidebook.

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

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

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

E. Insurers shall, upon the request of a claimant, include the deductible of a first party claimant, if any, in subrogation demands. Subrogation recoveries shall be shared on a proportionate basis with a first party claimant, unless the deductible amount has been otherwise recovered. No deduction for expenses shall be made from a deductible recovery unless an outside attorney is retained to

collect such recovery. The deduction shall then be made for only a pro rata share of the allocated loss adjustment expense.

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

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

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

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

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

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

L. In the event of payment of a total loss to a third party claimant, the insurer shall include any registered lienholder as copayee to the extent of the lienholder's interest.

M. As used in this section, "total loss" means that the vehicle repair costs plus the salvage value of the vehicle meets or exceeds

the actual cash value of the motor vehicle prior to the loss, as provided in used automobile dealer guidebooks.

N. An insurer shall not offer a cash settlement as provided in paragraph 2 of subsection A of this section for the purchase of a comparable motor vehicle and then subsequently sell the motor vehicle which has been determined to be a total loss back to the claimant if the insurer has determined that the repair of the vehicle would not result in the vehicle being restored to operative condition as provided in Section 1111 of Title 47 of the Oklahoma Statutes unless the claimant specifies in writing or via an electronic signature that the claimant understands that the motor vehicle shall be titled as a "junked vehicle".

Added by Laws 1986, c. 251, § 19, eff. Nov. 1, 1986. Amended by Laws 1987, c. 175, § 12, eff. Nov. 1, 1987; Laws 1993, c. 225, § 1, eff. Sept. 1, 1993; Laws 1994, c. 342, § 8, eff. Sept. 1, 1994. Renumbered from § 1257 of this title by Laws 1994, c. 342, § 20, eff. Sept. 1, 1994. Amended by Laws 2001, c. 363, § 13, eff. July 1, 2001; Laws 2003, c. 358, § 1, eff. Nov. 1, 2003; Laws 2010, c. 321, § 1, eff. Nov. 1, 2010; Laws 2021, c. 478, § 9, emerg. eff. May 12, 2021.

§36-1250.9. Periodic reports.

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

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

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

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

4. The total number of written claims for which lawsuits were instituted against the insurer, including the original amount of the

claim filed for by the insured, the amount of final adjudication, the reason for the lawsuit and the classification by line of insurance of each individual written claim, for the past twelve-month period or from the date of the insurer's last periodic report, whichever time is shorter; and

5. All information required by paragraph 14 of Section 1250.5 of this title.

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

Added by Laws 1986, c. 315, § 7, emerg. eff. June 24, 1986. Amended by Laws 1992, c. 74, § 3, eff. Sept. 1, 1992; Laws 1994, c. 342, § 9, eff. Sept. 1, 1994. Renumbered from § 1223 of this title by Laws 1994, c. 342, § 20, eff. Sept. 1, 1994. Amended by Laws 1994, 2nd Ex. Sess., c. 1, § 6, emerg. eff. Nov. 4, 1994; Laws 2013, c. 254, § 21, eff. Jan. 1, 2015; Laws 2024, c. 195, § 6, eff. Nov. 1, 2024.

§36-1250.10. Enforcement - Standards of performance - Complaints - Investigations.

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

B. The Commissioner shall compile the information received from an insurer pursuant to Section 1250.9 of this title in such a manner as to enable him to compare it to a minimum standard of performance which shall be promulgated by the Commissioner. If the Commissioner, after such comparison is made, finds that the insurer falls below the minimum standard of performance, he shall cause an investigation to be made of said insurer as to the reason, if any, for the substandard performance.

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

Added by Laws 1986, c. 315, § 8, emerg. eff. June 24, 1986. Amended by Laws 1994, c. 342, § 10, eff. Sept. 1, 1994. Renumbered from § 1224 of this title by Laws 1994, c. 342, § 20, eff. Sept. 1, 1994. Amended by Laws 1994, 2nd Ex. Sess., c. 1, § 7, emerg. eff. Nov. 4, 1994; Laws 2013, c. 254, § 22, eff. Jan. 1, 2015.

§36-1250.11. Statement of charges - Notice of hearing.

Upon the receipt of the results of an investigation instituted pursuant to the provisions of Section 1250.10 of this title, the Insurance Commissioner shall review the results and shall determine whether, by the standards set out in Sections 1250.3 and 1250.5 of this title, further action is required. If the Insurance Commissioner deems further action necessary, the Commissioner shall issue and serve upon the insurer a statement of the charges and a notice in accordance with the Administrative Procedures Act. No insurer shall be deemed in violation of the Unfair Claims Settlement Practices Act solely by reason of the numbers and types of such complaints or claims.

Added by Laws 1986, c. 315, § 9, emerg. eff. June 24, 1986. Amended by Laws 1994, c. 342, § 11, eff. Sept. 1, 1994. Renumbered from § 1225 of this title by Laws 1994, c. 342, § 20, eff. Sept. 1, 1994. Amended by Laws 1994, 2nd Ex. Sess., c. 1, § 8, emerg. eff. Nov. 4, 1994; Laws 1997, c. 418, § 55, eff. Nov. 1, 1997; Laws 2013, c. 254, § 23, eff. Jan. 1, 2015.

§36-1250.12. Repealed by Laws 1997, c. 418, § 125, eff. Nov. 1, 1997.

§36-1250.13. Cease and desist order - Enforcement.

A. The Insurance Commissioner, upon finding an insurer in violation of any provision of the Unfair Claims Settlement Practices Act, shall issue a cease and desist order to said insurer directing it to stop such unlawful practices. If the insurer refuses or fails to comply with said order, the Commissioner shall have the authority to revoke or suspend the insurer's certificate of authority. The Commissioner shall also have the authority to limit, regulate, and control the insurer's line of business, the insurer's writing of policy forms or other particular forms, and the insurer's volume of its line of business or its writing of policy forms or other particular forms. The Commissioner shall use the above authority to the extent deemed necessary to obtain the insurer's compliance with the order. The Attorney General shall offer his assistance if requested by the Commissioner to enforce the Commissioner's orders.

B. Reasonable attorney fees shall be awarded the Commissioner if judicial action is necessary for the enforcement of the orders. Such fees shall be based upon those prevailing in the community. Fees collected by the Commissioner without the assistance of the Attorney General shall be credited to the Insurance Commissioner's Revolving Fund. Fees collected by the Attorney General shall be credited to the Attorney General's Revolving Fund.

Added by Laws 1986, c. 315, § 10, emerg. eff. June 24, 1986. Amended by Laws 1994, c. 342, § 13, eff. Sept. 1, 1994. Renumbered from § 1226 of this title by Laws 1994, c. 342, § 20, eff. Sept. 1, 1994. Amended by Laws 1994, 2nd Ex. Sess., c. 1, § 9, emerg. eff.

Nov. 4, 1994; Laws 1997, c. 418, § 56, eff. Nov. 1, 1997; Laws 2013, c. 254, § 24, eff. Jan. 1, 2015.

§36-1250.14. Violation of act - Penalty.

For any violation of the Unfair Claims Settlement Practices Act, the Insurance Commissioner may, after notice and hearing, subject an insurer to a civil penalty of not less than One Hundred Dollars (\$100.00) nor more than Five Thousand Dollars (\$5,000.00) for each occurrence. Such civil penalty may be enforced in the same manner in which civil judgments may be enforced.

Added by Laws 1986, c. 251, § 20, eff. Nov. 1, 1986. Amended by Laws 1994, c. 342, § 14, eff. Sept. 1, 1994. Renumbered from § 1258 of this title by Laws 1994, c. 342, § 20, eff. Sept. 1, 1994.

Amended by Laws 1994, 2nd Ex. Sess., c. 1, § 10, emerg. eff. Nov. 4, 1994; Laws 1997, c. 418, § 57, eff. Nov. 1, 1997; Laws 2009, c. 432, § 11, eff. July 1, 2009; Laws 2013, c. 254, § 25, eff. Jan. 1, 2015.

§36-1250.15. Judicial review.

Any insurer affected by an order of the Insurance Commissioner issued pursuant to the Unfair Claims Settlement Practices Act may seek judicial review of such order by filing a petition in the District Court of Oklahoma County within thirty (30) days after the insurer is notified of the order.

Added by Laws 1994, c. 342, § 15, eff. Sept. 1, 1994. Amended by Laws 1997, c. 418, § 58, eff. Nov. 1, 1997.

§36-1250.16. Rules and regulations.

The Insurance Commissioner shall formulate, adopt and promulgate rules for the implementation and administration of the Unfair Claims Settlement Practices Act.

Added by Laws 1986, c. 251, § 22, eff. Nov. 1, 1986. Amended by Laws 1994, c. 342, § 16, eff. Sept. 1, 1994. Renumbered from § 1260 of this title by Laws 1994, c. 342, § 20, eff. Sept. 1, 1994.

§36-1250.17. Nonemergency patient form - Perjury.

The Insurance Commissioner shall develop, by rule, a form to be presented to patients by health care providers prior to rendering nonemergency services. The form shall be designed to seek information from the patient to further determine the eligibility of the patient for benefits under the patient's insurance policy.

Making false statements on the form shall be regarded as willful misrepresentation.

Added by Laws 2009, c. 323, § 3, eff. Nov. 1, 2009. Amended by Laws 2011, c. 278, § 23, eff. Nov. 1, 2011.

§36-1251. Repealed by Laws 1994, c. 342, § 21, eff. Sept. 1, 1994.

§36-1252. Renumbered as § 1250.2 of this title by Laws 1994, c. 342, § 20, eff. Sept. 1, 1994.

§36-1253. Renumbered as § 1250.4 of this title by Laws 1994, c. 342, § 20, eff. Sept. 1, 1994.

§36-1254. Renumbered as § 1250.5 of this title by Laws 1994, c. 342, § 20, eff. Sept. 1, 1994.

§36-1255. Renumbered as § 1250.6 of this title by Laws 1994, c. 342, § 20, eff. Sept. 1, 1994.

§36-1256. Renumbered as § 1250.7 of this title by Laws 1994, c. 342, § 20, eff. Sept. 1, 1994.

§36-1257. Renumbered as § 1250.8 of this title by Laws 1994, c. 342, § 20, eff. Sept. 1, 1994.

§36-1258. Renumbered as § 1250.14 of this title by Laws 1994, c. 342, § 20, eff. Sept. 1, 1994.

§36-1259. Renumbered as § 1250.12 of this title by Laws 1994, c. 342, § 20, eff. Sept. 1, 1994.

§36-1260. Renumbered as § 1250.16 of this title by Laws 1994, c. 342, § 20, eff. Sept. 1, 1994.

§36-1415.2. Definitions.

As used in this act, the term:

1. "Exchange" means a state, federal, or partnership exchange or marketplace operating in Oklahoma pursuant to Section 1311 or Section 1321 of the federal act;

2. "Federal act" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and regulations or guidance issued under those acts;

3. "Navigator" means a person, including assistor, application counselor or other person, certified or designated by an exchange to facilitate enrollment in health benefit plans offered by an exchange or to perform any of the other acts described in Section 1311(i) of the federal act. Such term does not include a person licensed as a health insurance producer under the Oklahoma Producer Licensing Act. For the purposes of this act, if an organization or business entity serves as a navigator, an individual performing navigator duties for that organization or business entity shall be considered to be acting in the capacity of a navigator;

4. "Navigator entity" means an organization or business entity which employs or oversees the activities of a navigator or which has received and possesses funding for the purpose of employing or overseeing navigators;

5. "Personally identifiable information" means information which can identify an individual including, but not limited to, name, birth date, social security number, official state- or government-issued driver license or identification number, alien registration number, government passport number, employer or taxpayer identification number; and

6. "Registered navigator" means a navigator who has applied, been approved, and maintains approval under the requirements of this act.

Added by Laws 2014, c. 321, § 1, eff. Sept. 1, 2014. Amended by Laws 2015, c. 145, § 1, eff. Nov. 1, 2015.

§36-1415.3. Navigator registration - Application - Requirements - Violations.

A. No navigator shall provide assistance with regard to health benefit plans as a navigator in this state under the provisions of the federal act unless registered in accordance with this act. The Insurance Commissioner must maintain a registry of navigators.

B. An individual applying for a navigator registration shall make application on a form developed by the Commissioner and shall declare under penalty of refusal, suspension, or revocation of the registration that the statements made in the application are true, correct, and complete to the best of the applicant's knowledge. The Commissioner may not allow any applicant to register who does not meet or conform to the following qualifications or requirements:

1. The applicant shall establish to the satisfaction of the Commissioner that he or she has read and will comply with written materials provided by the Commissioner concerning ethics, consumer privacy, the insurance laws of this state, and any other topic or topics the Commissioner deems necessary and attests to such understanding and intent to comply with all state statutes and rules;

2. The applicant shall attest to an understanding of the disclosure and recordkeeping requirements of the registry and the ability to provide and maintain such documents;

3. An applicant shall be not less than eighteen (18) years of age and of good moral character;

4. The applicant shall successfully complete a criminal history and regulatory background investigation in the manner that the Commissioner requires;

5. The applicant shall identify the entity with which he or she is, or will be, affiliated and supervised; and

6. The applicant shall pay a registration fee prescribed by the Commissioner not to exceed Fifty Dollars (\$50.00).

C. An entity applying for a navigator entity registration shall make application on a form developed by the Commissioner and shall declare under penalty of refusal, suspension or revocation of the registration that the statements made in the application are true, correct and complete to the best of the applicant's knowledge. The Commissioner shall not issue a registration to any entity applicant that does not meet or conform to the following qualifications or requirements:

1. Establishes policies and procedures to ensure that acts that may be performed only by a registered navigator or licensed producer are performed by persons who are appropriately registered or licensed;

2. Acknowledges and accepts legal responsibility for the acts of the individual navigators that it employs, supervises, or is affiliated with that are performed in this state and that are within the scope of the navigator's apparent authority; and

3. Pays a registration fee prescribed by the Commissioner not to exceed Fifty Dollars (\$50.00).

D. The registration of an individual navigator or navigator entity shall expire one year after issuance. An individual applicant for a renewal registration shall provide proof that he or she has completed continuing education as required under the federal act and shall establish to the satisfaction of the Commissioner that he or she has read and will comply with written materials provided by the Commissioner concerning ethics, consumer privacy, the insurance laws of this state and any other topic or topics the Commissioner deems necessary and attests to such understanding and intent to comply with all state statutes and rules.

E. A registered individual navigator must:

1. Provide a disclaimer in a form prescribed by the Commissioner to each individual or group whom the navigator assists, which shall include the name of the navigator and the navigator entity;

2. Record the name and contact information for each individual or group whom the navigator assists in enrolling on the exchange and the date of contact and provide such information to the navigator entity immediately;

3. Allow for an on-site inspection of operations and records specifically related to the fulfillment of the enrollment or assistance with enrollment duties as required by this act by the navigator at any time, including providing summary reports as requested by the Commissioner, which shall not include personally identifiable information. Provided, however, a registered individual navigator shall, upon inquiry by the Commissioner, verify

the name, contact information, and date of contact for an individual or group assisted in enrolling on the exchange by the navigator;

4. Report to the Commissioner any administrative action taken by a governmental agency against the navigator in this state or in any other jurisdiction within thirty (30) calendar days of the final disposition of the matter;

5. Report to the Commissioner any criminal prosecution of the navigator taken in any jurisdiction within thirty (30) calendar days of the initial pretrial hearing date; and

6. Notify the Commissioner within ten (10) calendar days of any action by an exchange or related party that restricts or terminates the navigator's authorization to act as a navigator.

F. A registered navigator entity must:

1. Maintain a record of all individuals employed or overseen as a navigator for a period of three (3) years following the termination of the employment or oversight of the individual as a navigator;

2. Maintain all records required to be provided to the navigator entity by registered navigators for a period of three (3) years following the termination of the employment or oversight of each individual as a navigator;

3. Allow for an on-site inspection of operations and records specifically related to the fulfillment of the enrollment or assistance with enrollment duties as required by this act by the navigator at any time, including providing summary reports as requested by the Commissioner, which shall not include personally identifiable information. Provided, however, a registered navigator entity shall, upon inquiry by the Commissioner, verify the name, contact information, and date of contact for an individual or group assisted in enrolling on the exchange by any navigator employed or overseen by the navigator entity;

4. Provide the Commissioner with a list of all individual navigators that it employs, supervises or is affiliated with, in a manner prescribed by the Commissioner; and

5. Report to the Commissioner any termination of employment, engagement, affiliation or other relationship with an individual navigator within thirty (30) days, using a format prescribed by the Commissioner, if the navigator is terminated for failing to comply with any requirement of this title.

G. Any person who acts as a navigator without holding an active registration at the time of the action shall be guilty of a misdemeanor and shall be punished by the imposition of a fine of not more than Two Hundred Fifty Dollars (\$250.00) or imprisonment in the county jail for not less than three (3) months nor more than six (6) months, or be punished by both such fine and imprisonment.

H. Any navigator who violates the provisions of this act shall be subject to a civil fine of not less than Fifty Dollars (\$50.00) nor more than Five Hundred Dollars (\$500.00) for each occurrence.

I. Any navigator entity that allows an individual who is employed or overseen by the navigator entity to interact with individuals or groups performing any of the functions of a navigator without an active registration shall be subject to a civil fine of not more than Five Hundred Dollars (\$500.00) for each individual or group with whom the unregistered individual interacts as a navigator and a civil fine of not more than Fifty Dollars (\$50.00) for each day the unregistered individual performs acts as a navigator.

J. Any navigator entity that fails to retain the documentation required by this act shall be subject to a civil fine of not less than Fifty Dollars (\$50.00) nor more than Five Hundred Dollars (\$500.00) for each occurrence.

Added by Laws 2014, c. 321, § 2, eff. Sept. 1, 2014. Amended by Laws 2015, c. 145, § 2, eff. Nov. 1, 2015.

§36-1415.4. Navigator limitations and prohibited actions.

A. Violation of any provision of Title 36 of the Oklahoma Statutes or the federal Patient Protection and Affordable Care Act, including any act or omission that would be a ground for denial, suspension or revocation of the license of an insurance producer under the Oklahoma Producer Licensing Act and of the license of a managing general agent under the Managing General Agents Act, shall be a ground for the denial, suspension, revocation, or refusal to renew a registration, the levy of a fine or any combination of actions.

B. Registration as a navigator pursuant to the provisions of this act shall not constitute licensing as a producer as defined in the Oklahoma Producer Licensing Act.

C. Navigators shall not, except as specifically required by the provisions of the federal act:

1. Provide advice about which health benefit plan or benefits, terms and features of a particular health benefit plan are better or worse for a particular individual or business;

2. Recommend a particular health benefit plan or advise individuals or businesses about which health benefit plan to choose;

3. Receive any commission, compensation or anything of value from any insurer, health benefit plan, business or consumer for performing activities specifically required to be provided as a navigator pursuant to the provisions of the federal act;

4. Accept any compensation or anything of value that is dependent, in whole or in part, on whether a person enrolls in or purchases a health plan;

5. Offer gifts of any value to enrollees or prospective enrollees as an inducement to, or conditioned upon, the submission

of an application for health insurance or the purchase or renewal of a health plan;

6. Engage in door-to-door solicitations, make unsolicited telephone calls, or send unsolicited electronic communications;

7. Solicit any person that is known to be currently insured under a health benefit plan;

8. Engage in voter registration activities while performing the duties of a navigator;

9. Make or cause to be made any communication relating to the exchange, health benefit plans, an insurance contract, the insurance business, any insurer or any producer that contains false, deceptive or misleading information;

10. Engage in any unfair method of competition or any fraudulent, deceptive or dishonest act or practice; or

11. Violate any applicable insurance law or regulation of this state or any subpoena or order of the Commissioner.

Added by Laws 2014, c. 321, § 3, eff. Sept. 1, 2014.

§36-1415.5. Implementation of rules and regulations.

The Insurance Commissioner shall be authorized to adopt rules and regulations to effect the implementation of this act.

Added by Laws 2014, c. 321, § 4, eff. Sept. 1, 2014.

§36-1416. State Innovation Waiver

A. There is hereby authorized the creation and submission of a State Innovation Waiver for the purpose of creating Oklahoma health insurance products that improve health and healthcare quality while controlling costs.

B. The State Innovation Waiver may include multiple waiver submissions under federal waiver authorities, including:

1. Waivers as provided in Section 1332 of the federal Affordable Care Act for the purpose of waiving certain federal insurance and tax regulations to create more state flexibility within the health insurance market; and

2. Waivers as provided in Section 1115 of the federal Social Security Act for the purpose of participating in the Delivery System Reform Incentive Payment Program or uncompensated care pools or both the Delivery System Reform Incentive Payment Program and uncompensated care pools with the aim of incentivizing providers through payment for achieving better health outcomes.

C. The State Innovation Waiver shall be created consistent with the innovation design plan developed through the Oklahoma Health Improvement Plan. It shall be presented to the Oklahoma Legislature along with a summary of comments received from public hearings and shall include the identification of specific provisions of the Affordable Care Act to be waived in the State of Oklahoma.

D. Participating agencies, including but not limited to the State Department of Health, the Oklahoma Health Care Authority, the Department of Mental Health and Substance Abuse Services and the Insurance Department, shall develop the State Innovation Waiver with input from the private sector partners and various subject matter experts and submit any and all necessary information for approval to all relevant entities.

E. The Insurance Department is hereby authorized to conduct rate review for the individual and small group health insurance market upon implementation of the State Innovation Waiver under Section 1332 of the federal Affordable Care Act.

Added by Laws 2016, c. 306, § 1, eff. Nov. 1, 2016.

§36-1421. Repealed by Laws 2001, c. 156, § 34, eff. Nov. 1, 2001.

§36-1422. Renumbered as § 1435.2 of this title by Laws 2001, c. 156, § 35, eff. Nov. 1, 2001.

§36-1423. Renumbered as § 1435.3 of this title by Laws 2001, c. 156, § 35, eff. Nov. 1, 2001.

§36-1424. Repealed by Laws 1997, c. 418, § 125, eff. Nov. 1, 1997.

§36-1424.1. Renumbered as § 1435.33 of this title by Laws 2001, c. 156, § 35, eff. Nov. 1, 2001.

§36-1424.2. Repealed by Laws 1997, c. 418, § 125, eff. Nov. 1, 1997.

§36-1424.11. Renumbered as § 1435.20 of this title by Laws 2001, c. 156, § 35, eff. Nov. 1, 2001.

§36-1424.12. Renumbered as § 1435.34 of this title by Laws 2001, c. 156, § 35, eff. Nov. 1, 2001.

§36-1424.13. Renumbered as § 1435.32 of this title by Laws 2001, c. 156, § 35, eff. Nov. 1, 2001.

§36-1424.14. Renumbered as § 1435.21 of this title by Laws 2001, c. 156, § 35, eff. Nov. 1, 2001.

§36-1424.15. Renumbered as § 1435.35 of this title by Laws 2001, c. 156, § 35, eff. Nov. 1, 2001.

§36-1424.16. Renumbered as § 1435.36 of this title by Laws 2001, c. 156, § 35, eff. Nov. 1, 2001.

§36-1424.17. Renumbered as § 1435.37 of this title by Laws 2001, c. 156, § 35, eff. Nov. 1, 2001.

§36-1424.18. Repealed by Laws 2001, c. 156, § 34, eff. Nov. 1, 2001.

§36-1424.19. Renumbered as § 1435.38 of this title by Laws 2001, c. 156, § 35, eff. Nov. 1, 2001.

§36-1425. Renumbered as § 1435.23 of this title by Laws 2001, c. 156, § 35, eff. Nov. 1, 2001.

§36-1425.1. Renumbered as § 1426A of this title by Laws 1997, c. 418, § 127, eff. Nov. 1, 1997.

§36-1425.2. Renumbered as § 1435.24 of this title by Laws 2001, c. 156, § 35, eff. Nov. 1, 2001.

§36-1425.3. Repealed by Laws 2001, c. 156, § 34, eff. Nov. 1, 2001.

§36-1425.4. Renumbered as § 1435.25 of this title by Laws 2001, c. 156, § 35, eff. Nov. 1, 2001.

§36-1425.5. Repealed by Laws 2009, c. 176, § 59, eff. Nov. 1, 2009.

§36-1425.6. Renumbered as § 1435.26 of this title by Laws 2001, c. 156, § 35, eff. Nov. 1, 2001.

§36-1425.7. Repealed by Laws 2001, c. 156, § 34, eff. Nov. 1, 2001.

§36-1425.8. Renumbered as § 1435.39 of this title by Laws 2001, c. 156, § 35, eff. Nov. 1, 2001.

§36-1425.9. Repealed by Laws 2001, c. 156, § 34, eff. Nov. 1, 2001.

§36-1426. Renumbered as § 1435.10 of this title by Laws 2001, c. 156, § 35, eff. Nov. 1, 2001.

§36-1426.1. Repealed by Laws 1997, c. 418, § 125, eff. Nov. 1, 1997.

§36-1426A. Renumbered as § 1435.29 of this title by Laws 2001, c. 156, § 35, eff. Nov. 1, 2001.

§36-1427. Renumbered as § 1435.30 of this title by Laws 2001, c. 156, § 35, eff. Nov. 1, 2001.

§36-1427.1. Renumbered as § 1435.31 of this title by Laws 2001, c. 156, § 35, eff. Nov. 1, 2001.

§36-1428. Repealed by Laws 2001, c. 156, § 34, eff. Nov. 1, 2001.

§36-1429. Repealed by Laws 1997, c. 418, § 125, eff. Nov. 1, 1997.

§36-1430. Repealed by Laws 2001, c. 156, § 34, eff. Nov. 1, 2001.

§36-1431. Repealed by Laws 2001, c. 156, § 34, eff. Nov. 1, 2001.

§36-1431.1. Repealed by Laws 2001, c. 156, § 34, eff. Nov. 1, 2001.

§36-1432. Repealed by Laws 2001, c. 156, § 34, eff. Nov. 1, 2001.

§36-1433. Repealed by Laws 2001, c. 156, § 34, eff. Nov. 1, 2001.

§36-1435.1. Short title - Application of act.

A. This act shall be known and may be cited as the "Oklahoma Producer Licensing Act".

B. This act governs the qualifications and procedures for the licensing of insurance producers. It simplifies and organizes statutory language to improve efficiency, permits the use of new technology, and reduces costs associated with issuing and renewing insurance licenses.

C. This act does not apply to excess and surplus lines agents and brokers licensed, except for Section 13 of this act and except where specifically referenced in this act.

Added by Laws 2001, c. 156, § 1, eff. Nov 1, 2001.

§36-1435.2. Definitions.

As used in the Oklahoma Producer Licensing Act:

1. "Commissioner" means the Insurance Commissioner;

2. "Business entity" means a corporation, association, partnership, limited liability company, limited partnership, or other legal entity;

3. "Customer service representative" means an individual who is required to be licensed as an insurance producer under the laws of this state and assists the insurance producer, broker, or agency in transacting the business of insurance from the office of the insurance producer, broker, or agency;

4. "Home state" means the District of Columbia and any state or territory of the United States in which an insurance producer maintains the producer's principal place of residence or principal place of business and is licensed to act as an insurance producer;

5. "Insurance" means any of the lines of authority in this title including workers' compensation insurance. Any insurer

approved to offer workers' compensation insurance may appoint insurance producers. All producers appointed for workers' compensation insurance products must be licensed as insurance producers by the Oklahoma Insurance Department;

6. "Insurance consultant" means an individual or legal entity who is required to be licensed as an insurance producer under the laws of this state and, for a fee, is held out to the public as engaged in the business of offering any advice, counsel, opinion or service with respect to the benefits, advantages, or disadvantages promised under any policy of insurance that could be issued or delivered in this state;

7. "Insurance producer" means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance and includes a customer service representative and an insurance consultant. Any person not duly licensed as an insurance producer, surplus lines insurance broker, or limited lines producer who solicits a policy of insurance on behalf of an insurer shall be deemed to be acting as an insurance agent within the meaning of the Oklahoma Producer Licensing Act, and shall thereby become liable for all the duties, requirements, liabilities, and penalties to which an insurance producer of the company is subject, and the company by issuing the policy of insurance shall thereby accept and acknowledge the person as its agent in the transaction. For purposes of the laws of this state and the Oklahoma Insurance Code, the term "insurance agent" means an insurance producer properly appointed by an insurance carrier to act as an agent for that insurance carrier, pursuant to Section 1435.15 of this title;

8. "Insurer" has the meaning set out in Section 103 of this title;

9. "License" means a document issued by the Insurance Commissioner of this state authorizing a person to act as an insurance producer for the lines of authority specified in the document. The license itself does not create any authority, actual, apparent or inherent, in the holder to represent or commit an insurance carrier;

10. "Limited line credit insurance" includes credit life, credit disability, credit property, credit unemployment, involuntary unemployment, mortgage life, mortgage guaranty, mortgage disability, guaranteed automobile protection insurance, known as "gap" insurance, and any other form of insurance offered in connection with an extension of credit that is limited to partially or wholly extinguishing that credit obligation that the Insurance Commissioner determines should be designated a form of limited line credit insurance;

11. "Limited line credit insurance producer" means a person who sells, solicits or negotiates one or more forms of limited line

credit insurance coverage to individuals through a master, corporate, group or individual policy;

12. "Limited lines insurance" means limited line credit and those lines of insurance defined in Section 1435.20 of this title or any other line of insurance the Insurance Commissioner deems necessary to recognize for the purposes of complying with subsection E of Section 1435.9 of this title;

13. "Limited lines producer" means a person who is authorized by the Commissioner to sell, solicit or negotiate limited lines insurance. For purposes of the laws of this state and the Oklahoma Insurance Code, the term "limited insurance representative" shall have the same meaning as the term "limited lines producer";

14. "Managing general agent" means an individual or legal entity appointed, as an independent contractor, by one or more insurers to exercise general supervision over the business of the insurer in this state, with authority to appoint insurance producers for the insurer, and to terminate appointments for the insurer;

15. "Negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms or conditions of the contract, provided that the person engaged in that act either sells insurance or obtains insurance from insurers for purchaser;

16. "Person" means an individual or a business entity;

17. "Sell" means to exchange a contract of insurance, by any means, for money or its equivalent, on behalf of an insurance company;

18. "Solicit" means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular company;

19. "Surplus lines insurance broker" means an individual or legal entity who solicits, negotiates, or procures a policy of insurance in an insurance company not licensed to transact business in this state which cannot be procured from insurers licensed to do business in this state. All transactions under such license shall be subject to Article 11 of the Oklahoma Insurance Code;

20. "Terminate" means the cancellation of the relationship between an insurance producer and the insurer or the termination of a producer's authority to transact insurance;

21. "Uniform Business Entity Application" means the current version of the National Association of Insurance Commissioners (NAIC) Uniform Business Entity Application for resident and nonresident business entities; and

22. "Uniform Application" means the current version of the NAIC Uniform Application for resident and nonresident producer licensing. Added by Laws 1980, c. 164, § 2, emerg. eff. April 15, 1980. Amended by Laws 1995, c. 339, § 17, eff. Nov. 1, 1995; Laws 1997, c.

418, § 59, eff. Nov. 1, 1997; Laws 2001, c. 156, § 2, eff. Nov. 1, 2001. Renumbered from § 1422 of this title by Laws 2001, c. 156, § 35, eff. Nov. 1, 2001. Amended by Laws 2015, c. 298, § 7, eff. Nov. 1, 2015; Laws 2018, c. 88, § 1, eff. Nov. 1, 2018; Laws 2022, c. 225, § 1, eff. Nov. 1, 2022.

§36-1435.3. Agency of insurance producer - Authority - Commissions.

A. Every insurance producer, as defined pursuant to paragraph 7 of Section 1435.2 of this title, or limited lines producer who solicits or negotiates an application for insurance of any kind shall, in any controversy between the insured or the insured's beneficiary and the insurer, be regarded as representing the insurer and not the insured or the insured's beneficiary. This provision shall not affect the apparent authority of an insurance producer.

B. Every surplus lines insurance broker who solicits an application for insurance of any kind shall, in any controversy between the insured or the insured's beneficiary and the insurer issuing any policy upon such application, be regarded as representing the insured or the insured's beneficiary and not the insurer. Any company which directly or through its agents delivers in this state to any insurance broker, a policy of insurance pursuant to the application or request of such broker, acting for an insured other than himself or herself, shall be deemed to have authorized such broker to receive on its behalf, payment of any premium which is due on such policy of insurance at the time of its issuance or delivery.

C. Every licensed insurance producer shall be entitled to commissions on all premiums collected for group insurance policies negotiated by the insurance producer on behalf of an insurer and an insured shall be required to pay such commissions to the insurance producer, except entitlement to commissions shall automatically terminate without notice, effective on the date of the occurrence of any of the following events:

1. The insurance producer's license to engage in accident and health insurance business is terminated or revoked by this state or any other public authority for cause. As used in this paragraph, "cause" shall be defined as perpetration by the insurance producer of fraud or embezzlement;

2. Material breach of the insurance producer's contract with the account or insurer, excluding production requirements;

3. Termination of the insurance producer's "Agent of Record" relationship with the employer or account; or

4. Death of the insurance producer, unless the contract between the insurer states otherwise or the right to the commission has vested.

Recovery of such commissions shall be through civil action. In any action brought pursuant to this subsection, the court may award reasonable attorney fees to the prevailing party.

Added by Laws 1980, c. 164, § 3, emerg. eff. April 15, 1980.

Amended by Laws 1992, c. 261, § 2, eff. Sept. 1, 1992; Laws 1996, c. 246, § 2, eff. July 1, 1996; Laws 2001, c. 156, § 3, eff. Nov. 1, 2001. Renumbered from § 1423 of this title by Laws 2001, c. 156, § 35, eff. Nov. 1, 2001. Amended by Laws 2022, c. 225, § 2, eff. Nov. 1, 2022.

§36-1435.4. License required for selling, soliciting, or negotiating - Waiver of penalty.

A. A person shall not sell, solicit, or negotiate insurance in this state for any class or classes of insurance unless the person is licensed for that line of authority in accordance with the Oklahoma Producer Licensing Act.

B. A penalty for selling, soliciting, negotiating, or procuring surplus lines insurance in this state without a surplus lines broker license shall be waived if the Insurance Commissioner receives an application for licensure as a surplus lines broker within thirty (30) days from the effective date of the policy at issue.

Added by Laws 2001, c. 156, § 4, eff. Nov. 1, 2001. Amended by Laws 2008, c. 184, § 8, eff. July 1, 2008.

§36-1435.5. When license not required.

A. Nothing in the Oklahoma Producer Licensing Act shall be construed to require an insurer to obtain an insurance producer license. In this section, the term "insurer" does not include an insurer's officers, directors, employees, subsidiaries or affiliates.

B. A license as an insurance producer shall not be required of the following:

1. An officer, director or employee of an insurer or of an insurance producer, provided that the officer, director or employee does not receive any commission on policies written or sold to insure risks residing, located or to be performed in this state, and:

- a. the officer, director or employee's activities are executive, administrative, managerial, clerical or a combination of these, and are only indirectly related to the sale, solicitation or negotiation of insurance, or
- b. the officer, director or employee's function relates to underwriting, loss control, inspection or the processing, adjusting, investigating or settling of a claim on a contract of insurance, or

- c. the officer, director or employee is acting in the capacity of a special agent or agency supervisor assisting insurance producers where the person's activities are limited to providing technical advice and assistance to licensed insurance producers and do not include the sale, solicitation or negotiation of insurance;

2. A person who secures and furnishes information for the purpose of group life insurance, group property and casualty insurance, group annuities, group or blanket accident and health insurance; or for the purpose of enrolling individuals under plans, issuing certificates under plans or otherwise assisting in administering plans; or performs administrative services related to mass-marketed property and casualty insurance, where no commission is paid to the person for the service;

3. An employer or association or its officers, directors, employees, or the trustees of an employee trust plan, to the extent that the employers, officers, employees, director or trustees are engaged in the administration or operation of a program of employee benefits for the employer's or association's own employees or the employees of its subsidiaries or affiliates, which program involves the use of insurance issued by an insurer, as long as the employers, associations, officers, directors, employees or trustees are not in any manner compensated, directly or indirectly, by the company issuing the contracts;

4. Employees of insurers or organizations employed by insurers who are engaging in the inspection, rating or classification of risks, or in the supervision of the training of insurance producers and who are not individually engaged in the sale, solicitation or negotiation of insurance;

5. A person whose activities in this state are limited to advertising without the intent to solicit insurance in this state through communications in printed publications or other forms of electronic mass media whose distribution is not limited to residents of the state, provided that the person does not sell, solicit or negotiate insurance that would insure risks residing, located or to be performed in this state;

6. A person who is not a resident of this state who sells, solicits or negotiates a contract of insurance for commercial property and casualty risks to an insured with risks located in more than one state insured under that contract, provided that that person is otherwise licensed as an insurance producer to sell, solicit or negotiate that insurance in the state where the insured maintains its principal place of business and the contract of insurance insures risks located in that state;

7. A salaried full-time employee who counsels or advises his or her employer relative to the insurance interests of the employer or

of the subsidiaries or business affiliates of the employer, provided that the employee does not sell or solicit insurance or receive a commission; or

8. A volunteer counselor assisting Medicare beneficiaries with enrollment in Medicare Part D plans pursuant to the Federal Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. Law No. 108-173, provided that the volunteer counselor does not receive commissions or other valuable consideration from any person or plan for the enrollment, that the volunteer counselor has received education that is acceptable to the Insurance Commissioner on enrollment of Medicare beneficiaries in Medicare Part D, that the volunteer counselor is providing volunteer services as part of a sponsoring agency or organization acceptable to the Commissioner, and that supporting documentation and/or verification is provided to the Commissioner as set out by rule.

Added by Laws 2001, c. 156, § 5, eff. Nov. 1, 2001. Amended by Laws 2008, c. 184, § 9, eff. July 1, 2008.

§36-1435.6. Examinations.

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. Prior to completion and filing of the application, the Insurance Commissioner shall subject each applicant for license as an insurance producer, as defined pursuant to paragraph 7 of Section 1435.2 of this title, 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 except as provided in Section 1435.10 of this title. 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. An application for licensure shall be made within two (2) years after passing the examination.

J. An applicant who has failed to pass the examination for the license applied for may take the examination subsequent times. Examination fees for subsequent examinations shall not be waived.

K. 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.

Added by Laws 2001, c. 156, § 6, eff. Nov. 1, 2001. Amended by Laws 2002, c. 307, § 13, eff. Nov. 1, 2002; Laws 2004, c. 274, § 8, eff. July 1, 2004; Laws 2006, c. 264, § 44, eff. July 1, 2006; Laws 2009, c. 176, § 24, eff. Nov. 1, 2009; Laws 2011, c. 242, § 2 and Laws 2011, c. 293, § 2, eff. June 20, 2011; Laws 2012, c. 44, § 3, eff. Nov. 1, 2012; Laws 2022, c. 225, § 3, eff. Nov. 1, 2022.

NOTE: Laws 2011, c. 242, § 2 and Laws 2011, c. 293, § 2 made identical changes to this section.

§36-1435.7. Applications for resident and business entity insurance producer licenses - Requirements for approval.

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

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

Added by Laws 2001, c. 156, § 7, eff. Nov. 1, 2001. Amended by 2002, c. 307, § 14, eff. Nov. 1, 2002; Laws 2003, c. 150, § 3, eff. Nov. 1, 2003; Laws 2007, c. 125, § 10, eff. July 1, 2007; Laws 2007, c. 338, § 3, eff. July 1, 2007; Laws 2008, c. 184, § 10, eff. July

1, 2008; Laws 2009, c. 176, § 25, eff. Nov. 1, 2009; Laws 2011, c. 242, § 3 and Laws 2011, c. 293, § 3, eff. June 20, 2011.

NOTE: Laws 2011, c. 242, § 3 and Laws 2011, c. 293, § 3 made identical changes to this section.

§36-1435.7A. Repealed by Laws 2011, c. 242, § 18 and by Laws 2011, c. 293, § 18, eff. June 20, 2011.

§36-1435.8. Lines of authority - Continuation in effect of license - Reinstatement - Contracting by Insurance Commissioner with nongovernmental entities.

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 twelve (12) 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, physical residential address, physical business address, preferred mailing 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 by any means acceptable to the Insurance Commissioner of a change of legal name, address, or e-mail address within thirty (30) days of the change to permit the Insurance Commissioner to give proper notice to licensees. A change in legal name or address 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 shall 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.

Added by Laws 2001, c. 156, § 8, eff. Nov. 1, 2001. Amended by Laws 2002, c. 307, § 15, eff. Nov. 1, 2002; Laws 2006, c. 264, § 45, eff. July 1, 2006; Laws 2009, c. 176, § 26, eff. Nov. 1, 2009; Laws 2011, c. 242, § 4 and Laws 2011, c. 293, § 4, eff. June 20, 2011; Laws 2019, c. 294, § 2, eff. Nov. 1, 2019.

NOTE: Laws 2011, c. 242, § 4 and Laws 2011, c. 293, § 4 made identical changes to this section.

§36-1435.9. Nonresident producer license.

A. Unless denied licensure pursuant to Section 1435.13 of this title, a nonresident person shall receive a nonresident producer license if:

1. The person is currently licensed as a resident and in good standing in that person's home state;
2. The person has submitted the proper request for licensure and has paid the fees required by Section 1435.23 of this title;
3. The person has submitted or transmitted to the Insurance Commissioner the application for licensure that the person submitted to the person's home state, or in lieu of the same, a completed Uniform Application; and
4. The person's home state awards nonresident producer licenses to residents of this state on the same basis.

B. Any nonresident application submitted pursuant to this section shall constitute the applicant's designation of the Insurance Commissioner as the person upon whom may be served all lawful process in any action, suit, or proceeding instituted by or on behalf of any interested person arising out of the insurance business of the applicant in this state. This designation constitutes an agreement that said service of process is of the same legal force and validity as personal service of process in this state upon the nonresident licensee.

C. The Insurance Commissioner may verify the producer's licensing status through the Producer Database maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries.

D. A nonresident producer who moves from one state to another state or a resident producer who moves from this state to another state shall file a change of address and provide certification from the new resident state within thirty (30) days of the change of legal residence.

E. Notwithstanding any other provision of the Oklahoma Producer Licensing Act or of the Oklahoma Insurance Code, a person licensed as a surplus lines producer in that person's home state shall receive a nonresident surplus lines producer license pursuant to subsections A and B of this section.

F. Notwithstanding any other provision of the Oklahoma Producer Licensing Act, a person licensed as a limited line credit insurance or other type of limited lines producer in that person's home state shall receive a nonresident limited lines producer license, pursuant to subsections A and B of this section, granting the same scope of authority as granted under the license issued by the producer's home state. For the purpose of this subsection, limited line insurance is any authority granted by the home state which restricts the authority of the license to less than the total authority prescribed in the associated major lines pursuant to subsection A of Section 1435.8 of this title.

Added by Laws 2001, c. 156, § 9, eff. Nov. 1, 2001. Amended by Laws 2002, c. 307, § 16, eff. Nov. 1, 2002; Laws 2008, c. 184, § 11, eff. July 1, 2008.

§36-1435.10. Exemptions from examination requirement.

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 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.

Added by Laws 1980, c. 164, § 6, emerg. eff. April 15, 1980.

Amended by Laws 1983, c. 90, § 4, emerg. eff. May 9, 1983; Laws 1985, c. 258, § 3, eff. Nov. 1, 1985; Laws 1997, c. 418, § 79, eff. Nov. 1, 1997; Laws 2001, c. 156, § 10, eff. Nov. 1, 2001.

Renumbered from § 1426 of this title by Laws 2001, c. 156, § 35, eff. Nov. 1, 2001. Amended by Laws 2006, c. 264, § 46, eff. July 1, 2006; Laws 2009, c. 176, § 27, eff. Nov. 1, 2009.

§36-1435.11. Use of assumed name.

An insurance producer doing business under any name other than the producer's legal name is required to notify the Insurance Commissioner prior to using the assumed name.
Added by Laws 2001, c. 156, § 11, eff. Nov. 1, 2001.

§36-1435.12. Temporary license without examination - Protection of insureds and public.

A. The Insurance Commissioner may issue a temporary license for a period not to exceed one hundred eighty (180) days without requiring an examination if the Insurance Commissioner deems that the temporary license is necessary for the servicing of an insurance business in the following cases:

1. To the surviving spouse or court-appointed personal representative of a licensed insurance producer who dies or becomes mentally or physically disabled to allow adequate time for the sale of the insurance business owned by the producer or for the recovery or return of the producer to the business or to provide for the training and licensing of new personnel to operate the producer's business;

2. To a member or employee of a business entity licensed as an insurance producer, upon the death or disability of an individual designated in the business entity application or the license;

3. To the designee of a licensed insurance producer entering active service in the Armed Forces of the United States of America; or

4. In any other circumstance in which the Insurance Commissioner deems that the public interest will best be served by the issuance of this license.

B. The Insurance Commissioner may by order limit the authority of any temporary licensee in any way deemed necessary to protect insureds and the public. The Insurance Commissioner may require the temporary licensee to have a suitable sponsor who is a licensed producer or insurer and who assumes responsibility for all acts of the temporary licensee and may impose other similar requirements designed to protect insureds and the public. The Insurance Commissioner may by order revoke a temporary license if the interest of insureds or the public are endangered. A temporary license may not continue after the owner or the personal representative disposes of the business. If the applicant fails to pass the licensure examination, the temporary license shall terminate automatically.

C. As to a temporary agent's license issued because of the death or disability of an agent, no insurers shall be represented by the temporary licensee in addition to those represented by the deceased or disabled agent.

D. The fee paid for the temporary license shall not be applied upon the fee for any permanent license of the same category issued to the licensee before expiration of the temporary license.

E. No license issued pursuant to the provisions of subsection A of this section shall be effective for more than six (6) months. The Commissioner, in his discretion, may renew the license once upon proper application and for good cause. However, no temporary license shall be issued for any line of insurance to any applicant who has failed to pass the required examination.

Added by Laws 2001, c. 156, § 12, eff. Nov. 1, 2001.

§36-1435.13. Suspension, revocation or refusal to issue or renew license - Probation and censure - Grounds - Notice - Fines.

A. The Insurance Commissioner may place on probation, censure, suspend, revoke or refuse to issue or renew a license issued pursuant to the Oklahoma Producer Licensing Act or may levy a civil penalty in accordance with subsection D of this section or any combination of actions, for any one or more of the following causes:

1. Providing incorrect, misleading, incomplete or materially untrue information in the license application;

2. Violating any insurance laws, or violating any regulation, subpoena or order of the Insurance Commissioner or of another state's Insurance Commissioner;

3. Obtaining or attempting to obtain a license through misrepresentation or fraud;

4. Improperly withholding, misappropriating or converting any monies or properties received in the course of doing insurance business;

5. Intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance;

6. Having been convicted of a felony;

7. Having admitted or been found to have committed any insurance unfair trade practice or fraud;

8. Using fraudulent, coercive or dishonest practices, or demonstrating incompetence, untrustworthiness or financial irresponsibility in the conduct of business in this state or elsewhere;

9. Having an insurance producer license, or its equivalent, denied, suspended, censured, placed on probation or revoked in any other state, province, district or territory;

10. Forging another's name to an application for insurance or to any document related to an insurance transaction;

11. Improperly using notes or any other reference material to complete an examination for an insurance license;

12. Knowingly accepting insurance business from an individual who is not licensed;

13. Failing to comply with an administrative or court order imposing a child support obligation;

14. Failing to pay state income tax or comply with any administrative or court order directing payment of state income tax;

15. Failing to respond to an inquiry from the Department as required in Section 1250.4 of this title; or

16. Any cause for which an original issuance of a license could have been refused.

B. In the event that the action by the Insurance Commissioner is to nonrenew or to deny an application for a license, the Insurance Commissioner shall notify the applicant or licensee and advise the applicant or licensee, in writing, of the reason for the denial or nonrenewal of the applicant's or licensee's license. The applicant or licensee may make written demand upon the Insurance Commissioner within thirty (30) days of the date of notification of the notification by the Insurance Commissioner for a hearing before the Insurance Commissioner or an independent hearing examiner to determine the reasonableness of the Insurance Commissioner's action. The hearing shall be heard within a reasonable time period and shall be held pursuant to the Oklahoma Administrative Procedures Act.

C. The license of a business entity may be suspended, revoked or refused if the Insurance Commissioner finds, after opportunity for hearing, that an individual licensee's violation was known or should have been known by one or more of the partners, officers or managers acting on behalf of the partnership or corporation and the violation was neither reported to the Insurance Commissioner nor corrective action taken.

D. In addition to or in lieu of any applicable denial, probation, censure, suspension or revocation of a license, a person may, after opportunity for hearing, be subject to a civil fine of not more than One Thousand Dollars (\$1,000.00) for each occurrence. The penalty may be enforced in the same manner in which civil judgments may be enforced.

E. Every licensee licensed pursuant to the provisions of the Oklahoma Producer Licensing Act shall keep at the licensee's place of business the usual and customary records pertaining to transactions authorized by the license. All records as to any particular transactions shall be kept available and open to the inspection of the Commissioner at any time during business hours during the three (3) years immediately following the date of completion of the transaction. The Commissioner may require a financial or market conduct examination during any investigation of a licensee. The cost of such examination shall be apportioned among all of the appointing insurers of the licensee.

F. The Insurance Commissioner shall retain the authority to enforce the provisions of and impose any penalty or remedy authorized by the Oklahoma Producer Licensing Act and this title against any person who is under investigation for or charged with a violation of the Oklahoma Producer Licensing Act or this title even if the person's license or registration has been surrendered or has lapsed by operation of law.

G. Files pertaining to investigations or legal matters which contain information concurring a current and ongoing investigation of allegations of violations of the Oklahoma Insurance Code by a licensed agent shall not be available for public inspection without proper judicial authorization; however, a licensee under investigation for alleged violations of the Oklahoma Insurance Code, or against whom an action for alleged violations of the Oklahoma Insurance Code has been commenced, may view evidence and complaints pertaining to the investigation, other than privileged information, at reasonable times at the Commissioner's office. All qualification examination materials, booklets and answers for any license authorized to be issued by the Commissioner under any statute shall not be available for public inspection. The residence address, residence telephone number, birth date and Social Security number of a licensee shall not be available for public inspection. A separate business or mailing address provided by the licensee shall be considered a public record. If the residence and business addresses or residence and business telephone numbers are the same, such addresses or telephone numbers shall be considered a public record.

H. The Commissioner shall promptly notify all appointing insurers, where applicable, and the licensee regarding any censure, suspension, revocation or termination of license by the Commissioner.

I. Upon suspension, revocation or termination of the license of a resident or nonresident of this state, the Commissioner shall notify the Central Office of the National Association of Insurance Commissioners, or its appropriate nonprofit affiliates and the Insurance Commissioner of each state for whom the Commissioner has executed a certificate of licensure status.

J. The Commissioner may issue a duplicate license for any lost, stolen or destroyed license issued pursuant to the Oklahoma Producer Licensing Act upon an affidavit of the licensee prescribed by the Commissioner concerning the facts of such loss, theft or destruction.

Added by Laws 2001, c. 156, § 13, eff. Nov. 1, 2001. Amended by Laws 2004, c. 274, § 9, eff. July 1, 2004; Laws 2007, c. 125, § 12, eff. July 1, 2007; Laws 2019, c. 294, § 3, eff. Nov. 1, 2019; Laws 2021, c. 408, § 1, eff. Nov. 1, 2021; Laws 2023, c. 196, § 1, eff. Nov. 1, 2023.

§36-1435.13a. Property and casualty insurance producers - Fiduciary duties - Violation - Punishment.

A. The provisions of this section shall apply only to property and casualty insurance producers. All premiums belonging to insurers and all unearned premiums belonging to insureds received by an insurance producer licensee under this article shall be treated by the insurance producer licensee in a fiduciary capacity.

1. All premiums received less commissions, if authorized, shall be remitted by the insurance producer licensee to the insurer or its agent entitled thereto on or before the contractual due date or, if there is no contractual due date, within forty-five (45) days after receipt.

2. All returned premiums received from insurers or credited by insurers to the account of the insurance producer licensee shall be remitted to or credited to the account of the licensee entitled thereto within thirty (30) days after receipt or credit.

3. An insurer or its agent shall promptly report to the Commissioner in writing the failure of any insurance producer to account for any collected premium to the insurer entitled to the accounting or to the insurer's agent entitled thereto for more than forty-five (45) days after the contractual due date or, if there is no contractual due date, more than ninety (90) days after receipt.

B. Every insurer shall remit unearned premiums to the insured or the proper agent or shall otherwise credit the account of the proper insurance producer licensee as soon as is practicable after entitlement thereto has been established but in no event more than forty-five (45) days after the effective date of any cancellation or termination effected by the insurer or after the date of entitlement thereto as established by notification of cancellation or of termination or as otherwise established. Any insurance producer licensee having knowledge of a failure on the part of any insurer to comply with this subsection shall promptly report such failure to the Commissioner in writing.

C. No insurance producer licensee under this article shall commingle premiums belonging to insurers and returned premiums belonging to insureds with the personal funds of the insurance producer licensee or with any other funds except those directly connected with the producer licensee's insurance business.

D. Any insurer that delivers in this state a policy of insurance to an insurance producer licensee representing the interest of an insured upon the application or request of the insurance producer licensee shall be deemed to have authorized the producer to receive any premium due upon issuance or delivery of the policy on behalf of the insurer.

E. 1. An insurance producer licensee or surplus line producer convicted of knowingly misappropriating or knowingly converting to his or her own use or wrongfully withholding fiduciary moneys in the amount of One Hundred Fifty Dollars (\$150.00) or less is guilty of a misdemeanor punishable by a fine not to exceed One Thousand Dollars (\$1,000.00) or by imprisonment in the county jail for a term not to exceed one year or by both such fine and imprisonment.

2. An insurance producer licensee or surplus line producer with a second or subsequent conviction for knowingly misappropriating or knowingly converting to his or her own use or wrongfully withholding

fiduciary moneys in the amount of One Hundred Fifty Dollars (\$150.00) or less or who is convicted of knowingly misappropriating or knowingly converting to his or her own use or wrongfully withholding premiums in an amount in excess of One Hundred Fifty Dollars (\$150.00) is guilty of a felony punishable by a fine not to exceed Five Thousand Dollars (\$5,000.00) or by imprisonment in the custody of the Department of Corrections for a term not to exceed five (5) years or by both such fine and imprisonment.

F. The Commissioner may promulgate rules for the implementation of this section.

Added by Laws 2006, c. 264, § 48, eff. July 1, 2006.

§36-1435.14. Payment or acceptance of commission, service fee, brokerage or other valuable consideration - Recipient to be licensed.

A. An insurance company or insurance producer shall not pay a commission, service fee, brokerage or other valuable consideration to a person for selling, soliciting or negotiating insurance in this state if that person is required to be licensed under this act and is not so licensed.

B. A person shall not accept a commission, service fee, brokerage or other valuable consideration for selling, soliciting or negotiating insurance in this state if that person is required to be licensed under this act and is not so licensed.

C. Renewal or other deferred commissions may be paid to a person for selling, soliciting or negotiating insurance in this state if the person was required to be licensed under this act at the time of the sale, solicitation or negotiation and was so licensed at that time.

D. An insurer or insurance producer may pay or assign commissions, service fees, brokerages or other valuable consideration to an insurance agency or to persons who do not sell, solicit or negotiate insurance in this state, unless the payment would violate Section 1204 of Title 36 of the Oklahoma Statutes. Added by Laws 2001, c. 156, § 14, eff. Nov. 1, 2001.

§36-1435.15. Appointment of producer as agent of insurer - Notice of appointment - Discrimination among producers - Penalties.

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 agent 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 Commissioner pursuant to the laws of this state who is authorized in writing by the appointing insurer to file appointments for the appointing 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 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 an 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 fine and imprisonment.

Added by Laws 2001, c. 156, § 15, eff. Nov. 1, 2001. Amended by Laws 2002, c. 307, § 17, eff. Nov. 1, 2002; Laws 2007, c. 125, § 13, eff. July 1, 2007; Laws 2009, c. 176, § 28, eff. Nov. 1, 2009; Laws 2014, c. 275, § 7, eff. Nov. 1, 2014; Laws 2019, c. 294, § 4, eff. Nov. 1, 2019; Laws 2020, c. 37, § 1, eff. July 1, 2020.

§36-1435.16. Termination of appointment, employment, contract or other business relationship - Notification - Immunity from liability - Confidentiality - Final adjudicated actions.

A. An insurer or authorized representative of the insurer that terminates the appointment, employment, contract or other insurance business relationship with a producer shall notify the Insurance Commissioner within thirty (30) days following the effective date of the termination, using a format prescribed by the Insurance Commissioner, if the reason for termination is one of the reasons set forth in Section 13 of this act or the insurer has knowledge the producer was found by a court, government body, or self-regulatory organization authorized by law to have engaged in any of the activities in Section 13 of this act. Upon the written request of

the Insurance Commissioner, the insurer shall provide additional information, documents, records or other data pertaining to the termination or activity of the producer.

B. An insurer or authorized representative of the insurer that terminates the appointment, employment, or contract with a producer for any reason not set forth in Section 13 of this act, shall notify the Insurance Commissioner within thirty (30) days following the effective date of the termination, using a format prescribed by the Insurance Commissioner. Upon written request of the Insurance Commissioner, the insurer shall provide additional information, documents, records or other data pertaining to the termination.

C. The insurer or the authorized representative of the insurer shall promptly notify the Insurance Commissioner in a format acceptable to the Insurance Commissioner if, upon further review or investigation, the insurer discovers additional information that would have been reportable to the Insurance Commissioner in accordance with subsection A of this section had the insurer then known of its existence.

D. 1. Within fifteen (15) days after making the notification required by subsections A, B and C of this section, the insurer shall mail a copy of the notification to the producer at the producer's last-known address. If the producer is terminated for cause for any of the reasons listed in Section 13 of this act, the insurer shall provide a copy of the notification to the producer at the producer's last-known address by certified mail, return receipt requested, postage prepaid or by overnight delivery using a nationally recognized carrier.

2. Within thirty (30) days after the producer has received the original or additional notification, the producer may file written comments concerning the substance of the notification with the Insurance Commissioner. The producer shall, by the same means, simultaneously send a copy of the comments to the reporting insurer, and the comments shall become a part of the Insurance Commissioner's file and accompany every copy of a report distributed or disclosed for any reason about the producer as permitted under subsection F of this section.

E. 1. In the absence of actual malice, an insurer, the authorized representative of the insurer, a producer, the Insurance Commissioner, or an organization of which the Insurance Commissioner is a member and that compiles the information and makes it available to other Insurance Commissioners or regulatory or law enforcement agencies shall not be subject to civil liability, and a civil cause of action of any nature shall not arise against these entities or their respective agents or employees, as a result of any statement or information required by or provided pursuant to this section or any information relating to any statement that may be requested in writing by the Insurance Commissioner, from an insurer or producer;

or a statement by a terminating insurer or producer to an insurer or producer limited solely and exclusively to whether a termination for cause under subsection A of this section was reported to the Insurance Commissioner, provided that the propriety of any termination for cause under subsection A of this section is certified in writing by an officer or authorized representative of the insurer or producer terminating the relationship.

2. In any action brought against a person that may have immunity under paragraph 1 of this subsection for making any statement required by this section or providing any information relating to any statement that may be requested by the Insurance Commissioner, the party bringing the action shall plead specifically in any allegation that paragraph 1 of this subsection does not apply because the person making the statement or providing the information did so with actual malice.

3. Paragraph 1 or 2 of this subsection shall not abrogate or modify any existing statutory or common law privileges or immunities.

F. 1. Any documents, materials or other information in the control or possession of the Department of Insurance that is furnished by an insurer, producer or an employee or agent thereof acting on behalf of the insurer or producer, or obtained by the Insurance Commissioner in an investigation pursuant to this section shall be confidential by law and privileged, shall not be subject to the Open Records Act, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the Insurance Commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the Insurance Commissioner's duties.

2. Neither the Insurance Commissioner nor any person who received documents, materials or other information while acting under the authority of the Insurance Commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to paragraph 1 of this subsection.

3. In order to assist in the performance of the Insurance Commissioner's duties under this act, the Insurance Commissioner:

- a. may share documents, materials or other information, including the confidential and privileged documents, materials or information subject to paragraph 1 of this subsection, with other state, federal, and international regulatory agencies, with the National Association of Insurance Commissioners, its affiliates or subsidiaries, and with state, federal, and international law enforcement authorities, provided that the recipient agrees to maintain the

confidentiality and privileged status of the document, material or other information,

- b. may receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the National Association of Insurance Commissioners, its affiliates or subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information, and
- c. may enter into agreements governing sharing and use of information consistent with this subsection.

4. No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the Commissioner under this section or as a result of sharing as authorized in paragraph 3 of this subsection.

5. Nothing in the Oklahoma Producer Licensing Act shall prohibit the Insurance Commissioner from releasing final, adjudicated actions including for cause terminations that are open to public inspection pursuant to the Open Records Act to a database or other clearinghouse service maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries of the National Association of Insurance Commissioners.

G. An insurer, the authorized representative of the insurer, or producer that fails to report as required under the provisions of this section or that is found to have reported with actual malice by a court of competent jurisdiction may, after notice and hearing, have its license or certificate of authority suspended or revoked and may be fined in accordance with Section 13 of this act.

Added by Laws 2001, c. 156, § 16, eff. Nov. 1, 2001.

§36-1435.17. Waiver of requirements for nonresident producers - Reciprocity - Continuing education requirements.

A. The Insurance Commissioner shall waive any requirements for a nonresident producer license applicant with a valid license from the applicant's home state, except the requirements imposed by Section 9 of this act, if the applicant's home state awards nonresident licenses to residents of this state on the same basis.

B. A nonresident producer's satisfaction of the producer's home state's continuing education requirements for licensed insurance producers shall constitute satisfaction of this state's continuing education requirements if the nonresident producer's home state

recognizes the satisfaction of its continuing education requirements imposed upon producers from this state on the same basis.
Added by Laws 2001, c. 156, § 17, eff. Nov. 1, 2001.

§36-1435.18. Administrative actions or criminal prosecutions against producer - Duty to report to Commissioner.

A. Whether an applicant for, a person licensed as or a person seeking a renewal for a producer license, that person shall report to the Insurance Commissioner any administrative action taken against that person in another jurisdiction or by another governmental agency in this state within thirty (30) days of the final disposition of the matter. This report shall include a copy of the order, consent to order or other relevant legal documents.

B. Within thirty (30) days of the initial pretrial hearing date, an applicant for, a person licensed as or a person seeking a renewal for a producer license shall report to the Insurance Commissioner any criminal prosecution of that person taken in any jurisdiction. The report shall include a copy of the initial complaint filed, the order resulting from the hearing and any other relevant legal documents.

C. Failure to comply with this statute shall result in immediate suspension of an application for, a license of or renewal of a producer license.

D. The provisions of this section shall apply to all licenses under Sections 4055.1 et seq. of this title, the Unauthorized Insurers and Surplus Lines Insurance Act, Section 1100 et seq. of this title, the Oklahoma Producer Licensing Act, Section 1435.1 et seq. of this title and the Insurance Adjusters Licensing Act, Section 6201 et seq. of this title.

Added by Laws 2001, c. 156, § 18, eff. Nov. 1, 2001. Amended by Laws 2019, c. 294, § 5, eff. Nov. 1, 2019.

§36-1435.19. Rules.

The Insurance Commissioner may, in accordance with Section 307.1 of Title 36 of the Oklahoma Statutes, promulgate reasonable rules as are necessary or proper to carry out the purposes of the Oklahoma Producer Licensing Act.

Added by Laws 2001, c. 156, § 19, eff. Nov. 1, 2001.

§36-1435.20. Limited lines producers - Qualification for license - Travel accident and baggage policies.

A. A limited lines producer may receive qualification for a license in one or more of the following categories:

1. Prepaid legal liability insurance, which means the assumption of an enforceable contractual obligation to provide specified legal services or to reimburse policyholders for specified

legal expenses, pursuant to the provisions of a group or individual policy;

2. Crop - insurance providing protection against damage to crops from unfavorable weather conditions, fire or lightning, flood, hail, insect infestation, disease or other yield-reducing conditions or perils provided by the private insurance market, or that is subsidized by the Federal Crop Insurance Corporation, including Multi-Peril Crop Insurance;

3. Car rental - insurance offered, sold or solicited in connection with and incidental to the rental of rental cars for a period of two (2) years, whether at the rental office or by preselection of coverage in master, corporate, group or individual agreements that:

- a. is nontransferable,
- b. applies only to the rental car that is the subject of the rental agreement, and
- c. is limited to the following kinds of insurance:
 - (1) personal accident insurance for renters and other rental car occupants, for accidental death or dismemberment, and for medical expenses resulting from an accident that occurs with the rental car during the rental period,
 - (2) liability insurance that provides protection to the renters and other authorized drivers of a rental car for liability arising from the operation or use of the rental car during the rental period,
 - (3) personal effects insurance that provides coverage to renters and other vehicle occupants for loss of, or damage to, personal effects in the rental car during the rental period,
 - (4) roadside assistance and emergency sickness protection insurance, or
 - (5) any other coverage designated by the Insurance Commissioner.

A car rental limited lines license issued to a rental or leasing company shall authorize any employee or authorized representative of the rental or leasing company to sell or offer coverage at each location at which the rental or leasing company operates. Employees or authorized representatives are not required to be individually licensed;

4. Credit - credit life, credit disability, credit property, credit unemployment, involuntary unemployment, mortgage life, mortgage guaranty, mortgage disability, guaranteed automobile protection insurance, or any other form of insurance offered in connection with an extension of credit that is limited to partially or wholly extinguishing that credit obligation and that is

designated by the Insurance Commissioner as limited line credit insurance;

5. Surety - insurance or bond that covers obligations to pay the debts of, or answer for the default of another, including faithlessness in a position of public or private trust. For purpose of limited line licensing, surety does not include surety bail bonds;

6. Travel;

7. Self-service storage insurance, pursuant to Section 1435.20a of this title; and

8. Motor Service Club limited lines producer, pursuant to Sections 3101 et seq. of this title.

B. 1. An insurance producer or limited lines producer may solicit applications for and issue travel accident policies or baggage insurance by means of mechanical vending machines supervised by the insurance producer or limited lines producer only if the Insurance Commissioner shall determine that the form of policy to be sold is reasonably suited for sale and issuance through vending machines, that use of vending machines for the sale of policies would be of convenience to the public, and that the type of vending machine to be used is reasonably suitable and practical for the sale and issuance of policies. Policies so sold do not have to be countersigned.

2. The Commissioner shall issue to the insurance agent or limited insurance representative a special vending machine license for each such machine to be used. The license shall specify the name and address of the insurer and licensee, the kind of insurance and type of policy to be sold, and the place where the machine is to be in operation. The license shall expire, be renewable, and be suspended or revoked coincidentally with the insurance agent license or limited representative license of the licensee. The license fee for each vending machine shall be that stated in the provisions of Section 1435.23 of this title. Proof of existence of the license shall be displayed on or about each machine in such manner as the Commissioner may reasonably require.

Added by Laws 1997, c. 418, § 60, eff. Nov. 1, 1997. Amended by Laws 1999, c. 36, § 1, eff. Nov. 1, 1999; Laws 1999, c. 333, § 1, eff. July 1, 1999; Laws 2000, c. 353, § 9, eff. Nov. 1, 2000; Laws 2001, c. 156, § 20, eff. Nov. 1, 2001. Renumbered from § 1424.11 of this title by Laws 2001, c. 156, § 35, eff. Nov. 1, 2001. Amended by Laws 2003, c. 150, § 4, eff. Nov. 1, 2003; Laws 2008, c. 184, § 12, eff. July 1, 2008; Laws 2013, c. 224, § 1, eff. Nov. 1, 2013; Laws 2014, c. 145, § 1, eff. Nov. 1, 2014; Laws 2018, c. 159, § 1, eff. Nov. 1, 2018; Laws 2019, c. 263, § 1, eff. Nov. 1, 2019; Laws 2021, c. 478, § 10, emerg. eff. May 12, 2021.

§36-1435.20a. Sale of storage insurance by self-storage facility.

A. As used in this section:

1. "Self-service storage insurance" means personal property insurance offered to occupants of a self-service storage facility in connection with and incidental to the rental of space at the self-service storage facility. Self-service storage insurance is limited to coverage against the loss of or physical damage to personal property that occurs on the premises of the self-service storage facility or when the personal property is in transit to or from the self-service storage facility during the period of the rental agreement;

2. "Occupant" means a person, or his or her sublessee, successor or assign, entitled to the use of the storage space at a self-service storage facility under a rental agreement, to the exclusion of others;

3. "Owner" means the owner, operator, lessor or sublessor of a self-service storage facility, or any person authorized by him or her to manage the facility or to receive rent from an occupant under a rental agreement;

4. "Self-service storage facility" means any real property designed and used for the purpose of renting or leasing individual storage space to occupants who are to have access to such facility for the purpose of storing and removing personal property;

5. "Supervising entity" means a business entity that is a licensed insurer or insurance producer.

B. The owner of a self-service storage facility may sell, solicit and offer coverage for self-service storage insurance.

C. An owner is required to hold a limited lines license, pursuant to Section 1435.20 of Title 36 of the Oklahoma Statutes, to sell, solicit or offer coverage for self-service storage insurance. An owner is not required to be licensed solely to display and make available brochures and other promotional materials created by or on behalf of an authorized insurer or surplus lines insurer. A limited lines license shall authorize any employee or authorized representative of the owner to sell, solicit and offer coverage for self-service storage insurance to occupants at each location at which the owner conducts business.

D. An owner holding a limited lines license pursuant to Section 1435.20 of Title 36 of the Oklahoma Statutes is exempt from the examination requirements in Section 1435.6 of Title 36 of the Oklahoma Statutes and the continuing education requirements in Section 1435.29 of Title 36 of the Oklahoma Statutes.

E. An owner or supervising entity shall maintain a registry of agents of the owner at each self-service storage facility who are engaged in selling, soliciting or offering self-service storage insurance coverage under the authority of the limited lines license of the owner.

F. Upon request by the Insurance Commissioner and with ten-days' notice, the books and records of the owner regarding the self-service storage insurance shall be open to examination by the Insurance Commissioner during regular business hours of the supervising entity.

G. At every location where self-service storage insurance is offered, brochures or other written or electronic materials must be made available to prospective purchasers which:

1. Disclose that self-service storage insurance may provide a duplication of coverage already provided by a homeowner's insurance policy, renter's insurance policy or other source of coverage of the occupant;

2. State that the purchase of the self-service storage insurance offered by the owner is not required in order to lease storage space;

3. Provide:

- a. the identity of the insurer,
- b. the identity of the owner,
- c. the process for filing a claim, and
- d. that the insured may cancel the coverage at any time and receive a refund of any applicable unearned premium.

H. Each prospective purchaser of self-service storage insurance shall be provided, prior to the time of sale, a copy of the policy or certificate, as applicable.

I. Self-service storage insurance may be provided under an individual, master, corporate, commercial or group insurance policy.

J. Self-service storage insurance rules, rates and forms are subject to the provisions of Sections 1201 through 1219, Sections 309.1 through 309.7, and Section 1435.26 of Title 36 of the Oklahoma Statutes.

K. The insurer issuing the self-service storage insurance shall either directly supervise or appoint a supervising entity to oversee compliance with applicable law. The insurer or supervising entity shall provide a training program for employees and authorized representatives of the owner that sell, solicit or offer self-service storage insurance. The training required by this subsection shall include each employee and authorized representative that sells, solicits or offers self-service storage insurance receiving basic instruction about the self-service storage insurance offered to occupants and the disclosures required pursuant to subsection G of this section.

L. No employee or authorized representative of an owner shall advertise, represent or otherwise hold himself or herself out as a licensed insurance producer, unless so licensed.

M. The premium for self-service storage insurance coverage may be billed and collected by the owner. The premium for the coverage

shall be separately itemized on the bill of the occupant. All premiums received by an owner for the sale of self-service storage insurance shall be considered funds held by the owner in a fiduciary capacity for the benefit of the insurer. An owner billing and collecting charges for self-service storage insurance shall not be required to maintain the funds in a segregated account provided that the owner is authorized by the insurer or supervising entity to hold the funds in an alternative manner and to remit the amounts to the supervising entity or insurer within sixty (60) days of receipt. Owners may receive compensation for billing and collection services.

N. A sworn application for a self-service storage insurance limited lines license provided for in Section 1435.20 of Title 36 of the Oklahoma Statutes shall be made to and filed with the Insurance Commissioner on forms prescribed and furnished by the Insurance Commissioner.

O. The application for licensure shall provide the name, residence address, principal place of business, facilities covered by the license, authorized representatives and other information required by the Insurance Commissioner for the owner and the licensed producer that is designated by the applicant as the person supervising compliance with the requirements of this section. Such information shall be updated within thirty (30) days of any change. The licensed producer that is designated by the applicant does not need to own or be employed by the owner.

P. Limited lines licenses for self-service storage insurance shall be valid for a period of twenty-four (24) months.

Q. Each owner licensed pursuant to this section shall pay to the Insurance Commissioner a fee as prescribed by the Insurance Commissioner.

Added by Laws 2019, c. 263, § 2, eff. Nov. 1, 2019.

§36-1435.21. Licensure for purposes of writing controlled business prohibited.

A. The Commissioner shall not grant, renew, continue, or permit to continue any license if the Commissioner finds that the license is being or will be used by the applicant or licensee for the purpose of writing controlled business. "Controlled business" means:

- a. insurance written on the interests of the licensee or those of his or her relatives to the second degree or of his or her employer, or
- b. insurance covering the licensee or relatives of the licensee to the second degree or a corporation, association, or partnership of which the licensee or a member of the licensee's immediate family is an officer, director, substantial stockholder, partner, associate, or employee, or the officers, directors,

substantial stockholders, partners, or employees of such a corporation, association, or partnership. A vendor's or lender's interest in property sold or being sold pursuant to contract or which is security for any loan shall not be deemed for the purpose of this provision to constitute property or an interest of the vendor or lender.

B. A license shall be deemed to have been or intended to be used for the purpose of writing controlled business if the Commissioner finds that during any twelve-month period the aggregate commissions earned from controlled business has exceeded twenty-five percent (25%) of the aggregate commissions earned on all business written by the applicant or licensee during the same period.

C. The prohibitions contained in this section concerning licensing for the writing of controlled business shall not apply to title insurance producers and limited lines producers. Added by Laws 1997, c. 418, § 63, eff. Nov. 1, 1997. Amended by Laws 2001, c. 156, § 21, eff. Nov. 1, 2001. Renumbered from § 1424.14 of this title by Laws 2001, c. 156, § 35, eff. Nov. 1, 2001.

§36-1435.22. Applicant to file bond prior to issuance of license.

1. Prior to issuance of a license as a surplus lines insurance broker, the applicant shall file with the Commissioner and thereafter, for as long as the license remains in effect, shall keep in force a bond in an amount of not less than Five Thousand Dollars (\$5,000.00) and not more than Forty Thousand Dollars (\$40,000.00) with an authorized corporate surety approved by the Commissioner. The exact amount of the bond shall be determined pursuant to the rules of the Commissioner and shall be based upon the actual or reasonably estimated premium for policies issued in connection with the services of the licensee. The surety shall notify the Commissioner of any changes in the bond of any licensee. The aggregate liability of the surety for any and all claims on a bond required by the provisions of this subsection shall in no event exceed the amount of the bond. No such bond shall be terminated unless at least thirty (30) days' prior written notice of the termination is given by the surety to the licensee and the Commissioner. Upon termination of the license for which the bond was in effect, the licensee shall notify the surety within ten (10) working days.

2. The Commissioner may waive bonding requirements for nonresident surplus lines insurance brokers.

3. All surety protection required by the provisions of this section is to inure to the benefit of any party aggrieved by the acts of a broker arising pursuant to conduct as a licensed surplus lines insurance broker.

Added by Laws 2001, c. 156, § 22, eff. Nov. 1, 2001. Amended by Laws 2002, c. 307, § 18, eff. Nov. 1, 2002; Laws 2022, c. 225, § 4, eff. Nov. 1, 2022.

§36-1435.23. License fees - Collection by Commissioner.

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. Insurance producer's study manual:
 - (1) Life, Accident & Health..... not to exceed \$ 40.00
 - (2) Property and Casualty..... not to exceed \$ 40.00
 - b. 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..... \$ 60.00
 - b. Nonresident insurance producer's biennial license..... \$100.00
 - c. Insurance producer's biennial license for sale or solicitation of variable insurance products..... \$ 60.00
 - d. Limited lines producer biennial license..... \$ 40.00
 - e. Nonresident limited lines producer biennial license..... \$100.00
 - f. (1) Car rental limited lines biennial license, one or two locations, resident or nonresident..... \$ 40.00
 - (2) Car rental limited lines biennial license, three or more locations, resident or nonresident..... \$500.00
 - g. Temporary license as agent..... \$ 20.00
 - h. Managing general agent's biennial license..... \$ 60.00
 - i. Surplus lines broker's biennial license..... \$100.00

j. Insurance vending machine, each machine,
biennial fee..... \$100.00

5. Annual fee for each appointed insurance
producer, managing general agent, or limited
lines producer by insurer, each license of
each insurance producer or representative..... \$30.00

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. 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.

C. 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.
Added by Laws 1980, c. 164, § 5, emerg. eff. April 15, 1980.

Amended by Laws 1981, c. 230, § 3, emerg. eff. June 22, 1981; Laws
1982, c. 221, § 2, operative Oct. 1, 1982; Laws 1983, c. 90, § 3,
emerg. eff. May 9, 1983; Laws 1983, c. 248, § 6, emerg. eff. June
21, 1983; Laws 1984, c. 173, § 3, emerg. eff. May 7, 1984; Laws
1984, c. 215, § 4, operative June 30, 1984; Laws 1985, c. 179, § 96,
operative July 1, 1985; Laws 1985, c. 258, § 2, eff. Nov. 1, 1985;
Laws 1987, c. 208, § 73, operative July 1, 1987; Laws 1987, c. 236,
§ 90, emerg. eff. July 20, 1987; Laws 1988, c. 116, § 3, eff. Nov.
1, 1988; Laws 1988, c. 204, § 2, operative July 1, 1988; Laws 1993,
c. 270, § 38, eff. Sept. 1, 1993; Laws 1994, c. 337, § 1, eff. Sept.
1, 1994; Laws 1995, c. 1, § 11, emerg. eff. March 2, 1995; Laws
1996, c. 246, § 4, eff. July 1, 1996; Laws 1997, c. 418, § 69, eff.
Nov. 1, 1997; Laws 2001, c. 156, § 23, eff. Nov. 1, 2001.

Renumbered from § 1425 of this title by Laws 2001, c. 156, § 35,
eff. Nov. 1, 2001. Amended by Laws 2002, c. 307, § 19, eff. Nov. 1,
2002; Laws 2006, c. 264, § 47, eff. July 1, 2006; Laws 2007, c. 125,
§ 14, eff. July 1, 2007; Laws 2008, c. 184, § 13, eff. July 1, 2008;
Laws 2009, c. 176, § 29, eff. Nov. 1, 2009; Laws 2009, c. 432, § 12,
eff. July 1, 2009; Laws 2011, c. 242, § 5; Laws 2011, c. 278, § 24;
Laws 2011, c. 293, § 5, emerg. eff. June 20, 2011; Laws 2011, c.
360, § 23; Laws 2013, c. 224, § 2, eff. Nov. 1, 2013; Laws 2022, c.
225, § 5, eff. Nov. 1, 2022.

NOTE: Laws 2011, c. 242, § 5 and Laws 2011, c. 293, § 5 made identical changes to this section. Laws 2011, c. 360, § 23 amended Laws 2011, c. 242, § 5, creating a version identical to Laws 2011, c. 278, § 24.

NOTE: Laws 1994, c. 272, § 4 and Laws 1994, c. 294, § 2 repealed by Laws 1995, c. 1, § 40, emerg. eff. March 2, 1995. Laws 1997, c. 133, § 447 repealed by Laws 1999, 1st Ex. Sess., c. 5, § 452, eff. July 1, 1999.

NOTE: Laws 1998, 1st Ex. Sess., c. 2, § 23 amended the effective date of Laws 1997, c. 133, § 447 from July 1, 1998, to July 1, 1999.

§36-1435.24. Repealed by Laws 2022, c. 225, § 8, eff. Nov. 1, 2022.

§36-1435.25. Repealed by Laws 2008, c. 184, § 32, eff. July 1, 2008.

§36-1435.26. Unlawful acts and penalties.

A. It shall be unlawful for any person whose license to act as an insurance producer, limited lines producer, managing general agent, or surplus lines insurance broker has been suspended, revoked, surrendered, or refused to do or perform any of the acts of an insurance producer, limited lines producer, managing general agent, or surplus lines insurance broker. Any person convicted of violating the provisions of this section shall be guilty of a felony and shall be punished by the imposition of a fine of not more than Five Thousand Dollars (\$5,000.00) or shall be committed to the custody of the Department of Corrections for not less than one (1) year nor more than five (5) years, or be punished by both said fine and commitment to custody.

B. It shall be unlawful for any insurance producer, limited lines producer, managing general agent, or surplus lines insurance broker to assist, aid, or conspire with a person whose license as an insurance producer, limited lines producer, managing general agent, or surplus lines insurance broker, has been suspended, revoked, surrendered, or refused to engage in any acts as an insurance producer, limited lines producer, managing general agent, or surplus lines insurance broker. Any person convicted of violating the provisions of this section shall be guilty of a felony and shall be punished by the imposition of a fine of not more than Five Thousand Dollars (\$5,000.00) or shall be committed to the custody of the Department of Corrections for not less than one (1) year nor more than five (5) years, or be punished by both said fine and commitment to custody.

C. Except for those persons exempt from licensure, it shall be unlawful for any person to do or perform any of the acts of an insurance producer, limited lines producer, managing general agent, or surplus lines insurance broker without being duly licensed. Any

person 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.

Added by Laws 1997, c. 418, § 75, eff. Nov. 1, 1997. Amended by Laws 2001, c. 156, § 26, eff. Nov. 1, 2001. Renumbered from § 1425.6 of this title by Laws 2001, c. 156, § 35, eff. Nov. 1, 2001. Amended by Laws 2022, c. 225, § 6, eff. Nov. 1, 2022.

§36-1435.27. Facsimile signature stamp as proof.

If an insurance producer or insurance producers choose to use a facsimile signature stamp in their business, such stamp shall be proof that the producer or producers have authorized the signing of any documents relating to the business of insurance.

Added by Laws 2001, c. 156, § 27, eff. Nov. 1, 2001.

§36-1435.28. Ownership interest by producer in policy - Insurable interest.

It shall be unlawful for any insurance producer to receive an ownership interest in any policy, by assignment or otherwise, unless the insurance producer has an insurable interest in the life of the insured.

Added by Laws 2001, c. 156, § 28, eff. Nov. 1, 2001.

§36-1435.29. Prelicensing and continuing education.

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 twenty-one (21) clock hours of continuing insurance education. Such education may include a written or oral examination.

2. 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, three (3) clock hours of ethics course work in this same period.

3. 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 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 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 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 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 a professional designation program, approved by the Insurance Commissioner, shall be deemed to have met the biennial requirement for continuing education.

The curriculum for the program shall total a minimum of twenty-four (24) hours within a twenty-four-month period. Each approved professional designation program included in this section shall be reviewed for quality and compliance every two (2) 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 two (2) 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. 1. Annual fees and course submission fees shall be set forth as a rule by the Commissioner. The fees are payable to the Insurance Commissioner. Provided, public-funded educational institutions, federal agencies, nonprofit organizations, not-for-profit organizations, and state agencies shall be exempt from this subsection.

2. The Commissioner may assess a civil penalty, after notice and opportunity for hearing, against a continuing education provider who fails to comply with the requirements of the Oklahoma Producer Licensing Act, of not more than Five Hundred Dollars (\$500.00), for each occurrence. The civil penalty may be enforced in the same manner in which civil judgments may be enforced.

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

E. Members of the Legislature shall be exempt from this section.

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

Added by Laws 1987, c. 198, § 1, eff. Nov. 1, 1987. Amended by Laws 1991, c. 204, § 12, eff. Sept. 1, 1991; Laws 1993, c. 270, § 39, eff. Sept. 1, 1993; Laws 1996, c. 246, § 5, eff. July 1, 1996; Laws 1997, c. 418, § 70, eff. Nov. 1, 1997. Renumbered from § 1425.1 of this title by Laws 1997, c. 418, § 127, eff. Nov. 1, 1997. Amended by Laws 2000, c. 353, § 12, eff. Nov. 1, 2000; Laws 2001, c. 156, § 29, eff. Nov. 1, 2001. Renumbered from § 1426A of this title by Laws 2001, c. 156, § 35, eff. Nov. 1, 2001. Amended by Laws 2002,

c. 307, § 20, eff. Nov. 1, 2002; Laws 2003, c. 150, § 5, eff. Nov. 1, 2003; Laws 2007, c. 125, § 15, eff. July 1, 2007; Laws 2008, c. 184, § 14, eff. July 1, 2008; Laws 2009, c. 176, § 30, eff. Nov. 1, 2009; Laws 2009, c. 432, § 13, eff. July 1, 2009; Laws 2011, c. 278, § 25, eff. Nov. 1, 2011; Laws 2012, c. 11, § 7, emerg. eff. April 4, 2012; Laws 2022, c. 225, § 7, eff. Nov. 1, 2022; Laws 2023, c. 196, § 2, eff. Nov. 1, 2023.

NOTE: Laws 2011, c. 242, § 6 repealed by Laws 2012, c. 11, § 8, emerg. eff. April 4, 2012. Laws 2011, c. 293, § 6 repealed by Laws 2012, c. 11, § 9, emerg. eff. April 4, 2012.

§36-1435.30. Repealed by Laws 2022, c. 225, § 9, eff. Nov. 1, 2022.

§36-1435.31. Repealed by Laws 2022, c. 225, § 10, eff. Nov. 1, 2022.

§36-1435.32. Repealed by Laws 2008, c. 184, § 32, eff. July 1, 2008.

§36-1435.33. Maximum agent's fees on renewals.

No life insurance company doing business in the State of Oklahoma shall charge a fee in excess of ten percent (10%) on any agent's renewals collected by said life insurance company.

Added by Laws 1984, c. 173, § 2, emerg. eff. May 7, 1984.

Renumbered from § 1424.1 of this title by Laws 2001, c. 156, § 35, eff. Nov. 1, 2001.

§36-1435.34. Repealed by Laws 2008, c. 184, § 32, eff. July 1, 2008.

§36-1435.35. Repealed by Laws 2008, c. 184, § 32, eff. July 1, 2008.

§36-1435.36. Certain information to be included on license - Term of license.

A. The name, mailing address of the licensee, expiration date, the line or lines of insurance coverage by the license, and such other information as the Commissioner deems proper for inclusion in the license shall be indicated on the license.

B. All licenses issued pursuant to the provisions of the Insurance Agents 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 Commissioner and by making appropriate adjustment in the biennial licensing fee.

Added by Laws 1997, c. 418, § 65, eff. Nov. 1, 1997. Renumbered from § 1424.16 of this title by Laws 2001, c. 156, § 35, eff. Nov. 1, 2001.

§36-1435.37. Repealed by Laws 2008, c. 184, § 32, eff. July 1, 2008.

§36-1435.38. Repealed by Laws 2004, c. 274, § 21, eff. July 1, 2004.

§36-1435.39. Refusal of license - Fees not refundable.

A. If the Insurance Commissioner finds that the applicant has not fully met the requirements for licensing, the Commissioner shall refuse to issue the license and promptly notify the applicant and the appointing insurer, when applicable, in writing, of the denial, stating the grounds therefor.

B. If for any reason a 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 24 of this act.

Added by Laws 1997, c. 418, § 77, eff. Nov. 1, 1997. Renumbered from § 1425.8 of this title by Laws 2001, c. 156, § 35, eff. Nov. 1, 2001.

§36-1435.40. Repealed by Laws 2021, c. 478, § 42, emerg. eff. May 12, 2021.

§36-1435.41. Providing insurance policy information - Exception.

A. An insurer shall provide to any insurance producer authorized to sell life, accident or health insurance products, whose appointment has been terminated for any reason other than the reasons set forth in Section 1435.13 of this title, information relating to the policy of the person who purchased a product from such producer if the insured has signed a form authorizing the release of the information.

B. The Insurance Commissioner shall prescribe the form required by subsection A of this section. The form shall be in compliance with federal and state laws and regulations relating to privacy.

C. This section shall not apply to any policy sold or serviced by the insurance producer while associated with the insurer's captive distribution system.

Added by Laws 2010, c. 201, § 1, eff. Nov. 1, 2010. Amended by Laws 2013, c. 224, § 3, eff. Nov. 1, 2013.

§36-1441. Short title.

Sections 1 through 13 of this act shall be known and may be cited as the "Third-party Administrator Act".

Added by Laws 1983, c. 89, § 1, eff. Nov. 1, 1983.

§36-1441.1. Administrator of certain group self-insurance associations exempted from act.

The provisions of Section 1441 et seq. of this title shall not apply to administrators of group self-insurance associations created pursuant to Section 103 of Title 85A of the Oklahoma Statutes. Added by Laws 1988, c. 164, § 1, emerg. eff. May 18, 1988. Amended by Laws 2015, c. 298, § 8, eff. Nov. 1, 2015; Laws 2018, c. 95, § 3, eff. Nov. 1, 2018.

§36-1442. Definitions.

As used in the Third-party Administrator Act, Section 1441 et seq. of this title:

1. "Administrator" means any person who collects premiums for an insurer or trust or who adjusts or settles claims for an insurer or trust, in connection with life or health insurance coverage, annuities or employee benefit stop loss in this state, but shall not include any person who collects premiums or who adjusts or settles claims under the following circumstances:

- a. any employer on behalf of the employees of that employer or the employees of one or more subsidiary or affiliated corporations of that employer,
- b. a union on behalf of its members,
- c. an insurance company which is licensed to transact insurance business in this state,
- d. a wholly owned subsidiary of an entity which is subject to the jurisdiction of the Insurance Commissioner,
- e. an insurance company acting as an insurer with respect to a policy lawfully issued and delivered by said company in and pursuant to the laws of this state,
- f. a hospital, medical, dental, or optometric service corporation or a health care service organization, including their agents, authorized by the Commissioner to issue contracts in this state pursuant to the provisions of the Oklahoma Insurance Code when engaged in the performance of their duties,
- g. a life or disability agent or broker who is licensed in this state and whose activities are limited exclusively to the sale of insurance,
- h. an adjuster licensed in this state for the kinds of business for which he is acting as an adjuster,
- i. a creditor insuring a debt between the creditor and its debtors on behalf of said creditor's debtors,

- j. a financial institution which is subject to supervision or examination by federal or state banking authorities,
- k. a company which issues credit cards and advances credit for and collects premiums or charges from its credit card holders who have authorized said collection, if the company does not adjust or settle claims,
- l. a person who adjusts or settles claims in the normal course of practice or employment as an attorney-at-law and who does not collect charges or premiums in connection with life or health insurance coverage or annuities,
- m. any workers' compensation trust, or
- n. a trust providing benefits to the employees of any political subdivision of a city, county or the state; and

2. "Trust" means any trust other than those exempted in paragraph 1 of this section which engages in the business of making contracts of insurance.

Added by Laws 1983, c. 89, § 2, eff. Nov. 1, 1983. Amended by Laws 1984, c. 173, § 5, emerg. eff. May 7, 1984; Laws 1987, c. 175, § 15, eff. Nov. 1, 1987; Laws 2008, c. 184, § 15, eff. July 1, 2008; Laws 2013, c. 254, § 26, eff. Jan. 1, 2015.

§36-1443. Written agreement required - Examination, audit and inspection of records.

A. No person shall act as an administrator without a written agreement between that person and an insurer. The written agreement shall be retained as part of the official records of both the insurer and the administrator for the duration of the agreement and for five (5) years thereafter.

B. The written agreement required by the provisions of subsection A of this section shall contain provisions stating any of the requirements of the Third-party Administrator Act which apply to the functions performed by the administrator.

C. If a policy is issued to a trustee, a copy of the trust agreement and any amendments to the agreement shall be furnished to the insurer by the administrator and shall be retained as part of the official records of both the insurer and the administrator for the duration of the policy and for five (5) years thereafter.

D. Every administrator shall maintain at the principal administrative office of the administrator for the duration of the agreement and for five (5) years thereafter the written agreement required by the provisions of this section and records of all transactions among the administrator, insurers or trusts, and insured persons.

E. 1. For the purposes of examination, audit, and inspection, the Insurance Commissioner or any other person in the course of examination, audit and inspection shall have access to books and records maintained by the administrator. Any trade secrets contained in these books and records, including the identity and addresses of policyholders and certificate holders, shall be confidential.

2. All work papers, recorded information, documents and copies thereof produced or obtained by or disclosed to the Commissioner or other person in the course of examination, audit and inspection made pursuant to this section, or in the course of analysis by the Commissioner or other person in the course of examination, audit and inspection, shall be given confidential treatment by the Commissioner and may not be made public by the Commissioner or any other person who obtained the information in the course of the examination, audit and inspection, except to the extent provided in this section. Access may be granted to the National Association of Insurance Commissioners. The parties shall agree in writing prior to receiving the information to provide to it the same confidential treatment as required by this section, unless the prior written consent of the company to which it pertains has been obtained. The confidentiality and protection from discovery by subpoena provided for in this paragraph shall not be construed to be extended to identical, similar or other related documents or information or to the work papers that are not deemed to be in the possession, custody or control of the Commissioner.

3. The Commissioner may use this information in any proceedings instituted against the administrator.

F. The insurer or trust shall have the right of continuing access to books and records maintained by the administrator sufficient to permit the insurer or trust to fulfill all of its contractual obligations to insured persons, subject to any restriction in the written agreement between the insurer or trust and the administrator concerning the proprietary rights of the parties to said books and records.

G. The agreement required by the provisions of this section shall include provisions stating the underwriting standards or other standards pertaining to the business underwritten by the insurer or trust.

Added by Laws 1983, c. 89, § 3, eff. Nov. 1, 1983. Amended by Laws 2010, c. 356, § 5, eff. Nov. 1, 2010; Laws 2012, c. 149, § 3, eff. Nov. 1, 2012.

§36-1444. Payments to administrator - Rights against administrator.

If an insurer or trust utilizes the services of an administrator pursuant to the terms of a written agreement, the payment to the administrator of any premiums or charges for insurance by or on

behalf of the insured shall be deemed to have been received by the insurer or trust. The payment of return premiums or claims by the insurer or trust to the administrator shall not be deemed payment to the insured or claimant until the payments are received by the insured or claimant. Nothing in the Third-party Administrator Act shall limit any right of the insurer or trust against the administrator resulting from failure of the administrator to make payments to the insurer or trust, insureds, or claimants. Added by Laws 1983, c. 89, § 4, eff. Nov. 1, 1983.

§36-1445. Fiduciary capacity and duties of administrator.

A. All insurance charges or premiums collected by an administrator for an insurer or trust and all return premiums received from the insurer or trust shall be held by the administrator in a fiduciary capacity. These funds shall be immediately remitted to the person entitled to the funds or shall be deposited promptly in a fiduciary bank account established and maintained by the administrator.

B. If charges or premiums deposited in a fiduciary account have been collected for more than one insurer or trust, the administrator shall keep records showing the deposits to and withdrawals from the account for each insurer or trust. The administrator, upon request of an insurer or trust, shall furnish copies of the records pertaining to deposits to and withdrawals from the account for that insurer or trust.

C. The administrator shall not pay any claim by withdrawals from a fiduciary account unless provisions for said withdrawals are included in the written agreement between the insurer or trust and the administrator. The written agreement shall authorize withdrawals by the administrator from the fiduciary account only for:

1. Remittance to an insurer or trust entitled to a remittance; or

2. Deposit in an account maintained in the name of an insurer or trust; or

3. Transfer to and deposit in an account established for payment of claims, as provided for by subsection D of this section; or

4. Payment to a group policyholder for remittance to the insurer or trust entitled to such remittance; or

5. Payment of commission, fees, or charges to the administrator; or

6. Remittance of return premiums to the person entitled to such return premiums.

D. All claims paid by the administrator from funds collected on behalf of the insurer or trust shall be paid on drafts, checks or electronic payment authorized by the insurer or trust.

Added by Laws 1983, c. 89, § 5, eff. Nov. 1, 1983. Amended by Laws 2021, c. 478, § 11, emerg. eff. May 12, 2021.

§36-1446. Advertising.

An administrator shall obtain approval from an insurer or trust before publishing any advertising pertaining to the business underwritten by the insurer or trust. For purposes of this section, "publication" includes mailing of advertising material.

Added by Laws 1983, c. 89, § 6, eff. Nov. 1, 1983.

§36-1447. Delivery of written communications to administrator - Compensation of administrator - Use of licensed agents.

A. Any policies, certificates, booklets, termination notices, or other written communications delivered by the insurer or trust to the administrator for delivery to policyholders shall be delivered by the administrator promptly after receipt of instructions to do so from the insurer or trust.

B. Compensation to an administrator for any policies for which the administrator adjusts or settles claims shall not be contingent upon claims experience. The provisions of this subsection shall not prevent basing the compensation of an administrator on the amount of premiums or charges collected or number of claims paid or processed or the number of covered insureds.

C. An administrator shall only use licensed insurance agents to do the business of insurance for trusts or insurers administered by the third-party administrator.

Added by Laws 1983, c. 89, § 7, eff. Nov. 1, 1983. Amended by Laws 1987, c. 175, § 16, eff. Nov. 1, 1987.

§36-1448. Administrator's bond - Amount - Requirements - Purpose - limits of cumulative liability - Cancellation.

A. Every administrator shall be bonded.

B. Prior to issuance of a license as an administrator, the applicant shall file with the Insurance Commissioner and thereafter keep in effect as long as the license remains in effect, a surety bond in an amount sufficient to protect those with whom the administrator deals, as determined by the Insurance Commissioner, which amount shall not be less than Ten Thousand Dollars (\$10,000.00), and in a form acceptable to the Insurance Commissioner. The bond is intended to secure performance of the administrator in conformity with the laws, rules and regulations governing third-party administrators. The bond shall be for the benefit of parties injured by the actions of the administrator.

C. In no event shall the cumulative liability of the Surety be more than the penal sum of the bond. In no event shall the Surety cancel the bond without first giving thirty (30) days' written notice to the principal and the Insurance Commissioner.

Added by Laws 1983, c. 89, § 8, eff. Nov. 1, 1983. Amended by Laws 1987, c. 172, § 2, eff. Nov. 1, 1987; Laws 1988, c. 164, § 2, emerg. eff. May 18, 1988; Laws 1997, c. 418, § 82, eff. Nov. 1, 1997.

§36-1449. Notice and information to be provided to insured individuals.

A. If the services of an administrator are utilized, the administrator shall provide a written notice to insured individuals advising them of the identities of the administrator, the policyholder, and the insurer or trust.

B. If an administrator collects funds from insured individuals, the administrator, upon request from an insured individual, shall furnish written information as to the amount of any charge or premium specified by the insurer or trust for insurance coverage for the insured individual. This information shall be furnished within ten (10) days after the administrator receives the request for information.

Added by Laws 1983, c. 89, § 9, eff. Nov. 1, 1983.

§36-1450. Licensing procedure - Violations.

A. No person shall act as or present himself or herself to be an administrator, as defined by the provisions of the Third-party Administrator Act, in this state, unless the person holds a valid license as an administrator which is issued by the Insurance Commissioner.

B. An administrator shall not be eligible for a nonresident administrator license under this section if the administrator does not hold a home state certificate of authority or license in a state that has adopted the Third-party Administrator Act or that applies substantially similar provisions as are contained in the Third-party Administrator Act to that administrator. If the Third-party Administrator Act in the administrator's home state does not extend to stop-loss insurance, but if the home state otherwise applies substantially similar provisions as are contained in the Third-party Administrator Act to that administrator, then that omission shall not operate to disqualify the administrator from receiving a nonresident administrator license in this state.

1. "Home state" means the United States jurisdiction that has adopted the Third-party Administrator Act or a substantially similar law governing third-party administrators and which has been designated by the administrator as its principal regulator. The administrator may designate either its state of incorporation or its principal place of business within the United States if that jurisdiction has adopted the Third-party Administrator Act or a substantially similar law governing third-party administrators. If neither the administrator's state of incorporation nor its principal place of business within the United States has adopted the Third-

party Administrator Act or a substantially similar law governing third-party administrators, then the third-party administrator shall designate a United States jurisdiction in which it does business and which has adopted the Third-party Administrator Act or a substantially similar law governing third-party administrators. For purposes of this paragraph, "United States jurisdiction" means the District of Columbia or a state or territory of the United States.

2. "Nonresident administrator" means a person who is applying for licensure or is licensed in any state other than the administrator's home state.

C. In the case of a partnership which has been licensed, each general partner shall be licensed and shall qualify therefore as though an individual licensee. The Commissioner shall charge a full additional license fee and a separate license shall be issued for each individual so named in the license. The partnership shall notify the Commissioner within thirty (30) days if any individual licensed on its behalf has been terminated, or is no longer associated with or employed by the partnership. Any person making application as an administrator or currently licensed as an administrator under the Third-party Administrator Act shall provide a National Association of Insurance Commissioners (NAIC) Biographical Affidavit.

D. An application for an administrator's license shall be in a form prescribed by the Commissioner and shall be accompanied by a fee of One Hundred Dollars (\$100.00). The application shall be filed and the fee shall be paid electronically in a form and manner prescribed by the Commissioner. This fee shall not be refundable if the application is denied or refused for any reason by either the applicant or the Commissioner.

E. The administrator's license shall continue in force no longer than twelve (12) months from the original month of issuance. Upon filing a renewal form prescribed by the Commissioner, accompanied by a fee of One Hundred Dollars (\$100.00), the license may be renewed annually for a one-year term. The renewal shall be filed, and the fee shall be paid electronically in a form and manner prescribed by the Commissioner. A license that expires for failure to submit a renewal application may be reinstated within ninety (90) days after the expiration date by electronically submitting a fee in an amount of Two Hundred Dollars (\$200.00) in a form and manner prescribed by the Commissioner and any other transaction or other fee deemed necessary by the Commissioner. All applications received after the license has expired for more than ninety (90) days shall include a detailed report of administrator services provided in this state during the period of expired licensure. The administrator shall submit, together with the application for renewal, a list of the names and addresses of the persons with whom the administrator has contracted in accordance with Section 1443 of this title. The

Commissioner shall hold this information confidential except as provided in Section 1443 of this title.

F. 1. The administrator's license may be issued or renewed by the Commissioner unless, after notice and opportunity for hearing, the Commissioner determines that the administrator is not competent, trustworthy, or financially responsible, or has had any insurance license denied for cause by any state, has been convicted or has pleaded guilty or nolo contendere to any felony or to a misdemeanor involving moral turpitude or dishonesty.

2. The administrator shall report to the Insurance Commissioner any administrative or criminal action taken against the administrator in another jurisdiction or by another governmental agency in this state within thirty (30) calendar days of the final disposition of the matter. This report shall include a copy of the order, consent to order, copy of any payment required as a result of the administrative or criminal action, or other relevant legal documents.

3. Any entity making application to the Insurance Department as a third-party administrator (TPA) or within thirty (30) days of a change for a licensed TPA shall provide current National Association of Insurance Commissioners (NAIC) Biographical Affidavits on behalf of all officers, directors and key managerial personnel of the TPA, and individuals with a ten percent (10%) or more beneficial ownership in the TPA and the TPA's ultimate controlling person (affiant) as required for insurers pursuant to the laws of this state.

G. After notice and opportunity for hearing, and upon determining that the administrator has violated any of the provisions of the Oklahoma Insurance Code or upon finding reasons for which the issuance or renewal of such license could have been denied, the Commissioner may deny, refuse to renew, suspend or revoke an administrator's license or assess a civil penalty not more than Five Thousand Dollars (\$5,000.00) for each occurrence, or any combination thereof. The payment of the penalty may be enforced in the same manner as civil judgments may be enforced.

H. Any person who is acting as or presenting himself or herself to be an administrator without a valid license shall be subject, upon conviction, to a fine not less than One Thousand Dollars (\$1,000.00) nor more than Ten Thousand Dollars (\$10,000.00) for each occurrence. This fine shall be in addition to any other penalties which may be imposed for violations of the Oklahoma Insurance Code or other laws of this state.

I. Except as provided for in subsections F and G of this section, any person convicted of violating any provisions of the Third-party Administrator Act shall be guilty of a misdemeanor and shall be subject to a fine not more than One Thousand Dollars (\$1,000.00).

J. Each administrator shall electronically submit, in a form and manner prescribed by the Commissioner, any change of legal business name, "doing business as" or assumed name, address, service agent contact information, or contact email address, and any necessary fees within thirty (30) days after the change occurred. Any submission of a change under this subsection that is received more than thirty (30) days after the change occurred shall be accompanied by a fee of Fifty Dollars (\$50.00).

K. Upon receipt of any inquiry from the Insurance Commissioner, a licensed administrator shall furnish the Commissioner with an adequate response to the inquiry within twenty (20) days from receipt of the inquiry.

Added by Laws 1983, c. 89, § 10, eff. Nov. 1, 1983. Amended by Laws 1984, c. 173, § 6, emerg. eff. May 7, 1984; Laws 1985, c. 258, § 4, eff. Nov. 1, 1985; Laws 1997, c. 418, § 83, eff. Nov. 1, 1997; Laws 2004, c. 274, § 10, eff. July 1, 2004; Laws 2008, c. 184, § 16, eff. July 1, 2008; Laws 2009, c. 432, § 14, eff. July 1, 2009; Laws 2019, c. 294, § 6, eff. Nov. 1, 2019; Laws 2021, c. 478, § 12, emerg. eff. May 12, 2021; Laws 2023, c. 149, § 1, eff. Nov. 1, 2023; Laws 2024, c. 195, § 7, eff. Nov. 1, 2024.

§36-1452. Annual report - Penalties for failure to file - Waiver.

A. On or before June 1 of each year, all licensed administrators shall file an annual report for the previous calendar year. Any report filed by an administrator with accumulated year-to-date premiums collected or claims paid of Fifty Thousand Dollars (\$50,000.00) or more, whichever is greater, shall have been reviewed by a certified public accountant who shall be independent of the administrator. The report shall be subscribed and sworn to by the president and attested to by the secretary or other proper officers substantiating that the information contained in the report is true and factual concerning each of the plans they administer which are governed pursuant to the provisions of the Third-party Administrator Act. The report shall include the name and address of each fund and a statement of fund equity, paid claims by the covered unit, the accumulated year-to-date paid claims, and the year-to-date reserve status. Failure of any third-party administrator to execute and file the annual reports as required by this section shall constitute cause, after notice and opportunity for hearing, for censure, suspension, or revocation of administrator licensure to transact business in this state, or a civil penalty of not less than One Hundred Dollars (\$100.00) or more than One Thousand Dollars (\$1,000.00) for each occurrence, or both censure, suspension, or revocation and civil penalty.

B. If a licensed administrator has had no business or activity in the past calendar year, has not administered any insurance plans or business in the past calendar year and no funds are under the

licensed administrator's oversight and administration, then the licensed administrator shall submit an application for waiver of the annual report described in subsection A of this section on a form prescribed by the Commissioner. Upon applying for a waiver, the administrator shall state under oath that the administrator has had no business, has not administered any funds and the licensee's administration of premiums and claims has been dormant for the past calendar year. The application must be submitted no later than April 1st on the form prescribed by the Commissioner.

Added by Laws 1983, c. 89, § 12, eff. Nov. 1, 1983. Amended by Laws 1994, c. 129, § 6, eff. Sept. 1, 1994; Laws 1997, c. 418, § 84, eff. Nov. 1, 1997; Laws 2002, c. 307, § 22, eff. Nov. 1, 2002; Laws 2007, c. 125, § 16, eff. July 1, 2007; Laws 2010, c. 222, § 25, eff. Nov. 1, 2010; Laws 2013, c. 269, § 2, eff. Nov. 1, 2013; Laws 2014, c. 145, § 2, eff. Nov. 1, 2014; Laws 2016, c. 73, § 3, eff. Nov. 1, 2016.

§36-1453. Repealed by Laws 1997, c. 418, § 125, eff. Nov. 1, 1997.

§36-1461. Repealed by Laws 2018, c. 88, § 2, eff. Nov. 1, 2018.

§36-1462. Repealed by Laws 2018, c. 88, § 2, eff. Nov. 1, 2018.

§36-1463. Repealed by Laws 2018, c. 88, § 2, eff. Nov. 1, 2018.

§36-1464. Repealed by Laws 2018, c. 88, § 2, eff. Nov. 1, 2018.

§36-1465. Repealed by Laws 2018, c. 88, § 2, eff. Nov. 1, 2018.

§36-1466. Repealed by Laws 2018, c. 88, § 2, eff. Nov. 1, 2018.

§36-1471. Short title.

This act shall be known and may be cited as the "Managing General Agents Act".

Added by Laws 1991, c. 134, § 1, eff. July 1, 1991.

§36-1472. Definitions.

As used in this act:

1. "Actuary" means a person who is a member in good standing of the American Academy of Actuaries;

2. "Insurer" means any person licensed pursuant to the Oklahoma Insurance Code to transact insurance;

3. a. "Managing General Agent" or "MGA" means any person who:

(1) manages all or part of the insurance business of an insurer, including the management of a

- separate division, department or underwriting office, and
- (2) acts as an agent for such insurer, whether known as a managing general agent, manager or other similar term, and
 - (3) directly or indirectly, with or without the authority of the insurer, whether separately or together with affiliates, produces and underwrites an amount of gross direct written premium equal to or greater than five percent (5%) of the policyholder surplus, as reported in the last annual statement of the insurer in any one quarter or year together with the following activities related to the business produced:
 - (a) adjusts or pays claims in excess of an amount determined by the Insurance Commissioner, or
 - (b) negotiates reinsurance on behalf of the insurer.
- b. Notwithstanding subparagraph a of this paragraph, the following persons shall not be considered to be managing general agents for the purpose of this act:
- (1) an employee of the insurer,
 - (2) a U.S. Manager of the United States branch of an alien insurer,
 - (3) an underwriting manager which, pursuant to contract:
 - (a) manages all the insurance operations of the insurer,
 - (b) is under common control with the insurer, subject to the holding company regulatory act, and
 - (c) whose compensation is not based on the volume of premiums written, and
 - (4) the attorney-in-fact authorized by and acting for the subscribers of a reciprocal insurer or interinsurance exchange under powers of an attorney;

4. "Underwrite" means the authority to accept or reject risk on behalf of the insurer.

Added by Laws 1991, c. 134, § 2, eff. July 1, 1991. Amended by Laws 1992, c. 65, § 3, eff. Sept. 1, 1992.

§36-1473. Agent license - Bond - Errors and omissions policy.

A. No person shall act in the capacity of a managing general agent with respect to risks located in this state for an insurer

unless such person is licensed as a producer pursuant to the Oklahoma Producer Licensing Act.

B. No person shall act in the capacity of a managing general agent, representing an insurer domiciled in this state with respect to risks located outside this state, unless such person is licensed as a producer pursuant to the Oklahoma Producer Licensing Act. Provided, such license may be a nonresident license.

C. The Insurance Commissioner may require a bond in the amount acceptable to the Commissioner for the protection of the insurer.

D. The Insurance Commissioner may require the managing general agent to maintain an errors and omissions policy.

Added by Laws 1991, c. 134, § 3, eff. July 1, 1991. Amended by Laws 2012, c. 44, § 4, eff. Nov. 1, 2012.

§36-1474. Written contract with insurer required - Minimum provisions.

No person acting in the capacity of a managing general agent shall place business with an insurer unless there is in force a written contract between the parties which sets forth the responsibilities of each party, and where both parties share responsibility for a particular function, specifies the division of such responsibilities, and which contains the following minimum provisions:

1. The insurer may terminate the contract for cause upon thirty (30) days' written notice to the managing general agent and the Insurance Commissioner. The insurer may suspend the underwriting authority of the managing general agent during the pendency of any dispute regarding the cause for termination;

2. The managing general agent shall render accounts to the insurer detailing all transactions and shall remit all funds due under the contract to the insurer on not less than a monthly basis;

3. All funds collected for the account of an insurer shall be held by the managing general agent in a fiduciary capacity in a bank which is a member of the Federal Reserve System. This account shall be used for all payments on behalf of the insurer. The managing general agent may retain no more than three (3) months' estimated claims payment and allocated loss adjustment expenses;

4. Separate records of business written by the managing general agent shall be maintained. The insurer shall have access to and the right to copy all accounts and records related to its business in a form usable by the insurer. The Insurance Commissioner shall have access to all books, bank accounts and records of the managing general agent in a form usable to the Commissioner. Such records shall be retained according to the provisions of subsection E of Section 1435.13 of this title;

5. The contract may not be assigned in whole or part by the managing general agent;

6. The contract shall contain appropriate underwriting guidelines including:

- a. the maximum annual premium volume,
- b. the basis of the rates to be charged,
- c. the types of risks which may be written,
- d. maximum limits of liability,
- e. applicable exclusions,
- f. territorial limitations,
- g. policy cancellation provisions, and
- h. the maximum policy period;

7. The insurer shall have the right to cancel or not renew any policy of insurance subject to applicable laws and regulations;

8. If the contract permits the managing general agent to settle claims on behalf of the insurer:

- a. all claims must be reported to the company in a timely manner,
- b. a copy of the claim file shall be sent to the insurer at its request or as soon as it becomes known that the claim:
 - (1) has the potential to exceed a threshold determined by the Insurance Commissioner or exceeds the limit set by the company, whichever is less,
 - (2) involves a coverage dispute,
 - (3) may exceed the managing general agent's claims settlement authority,
 - (4) is open for more than six (6) months, or
 - (5) is closed by payment of an amount set by the Insurance Commissioner or an amount set by the company, whichever is less,
- c. all claim files will be the joint property of the insurer and managing general agent. However, upon an order of liquidation of the insurer, such files shall become the sole property of the insurer or its estate and the managing general agent shall have reasonable access to and the right to copy the files on a timely basis,
- d. any settlement authority granted to the managing general agent may be terminated for cause upon the insurer's written notice to the managing general agent or upon the termination of the contract. The insurer may suspend the settlement authority during the pendency of any dispute regarding the cause for termination, and
- e. nothing in this section shall be construed to give the Insurance Commissioner authority to settle or adjust claims on behalf of the insurer;

9. Where electronic claim files are in existence, the contract shall address the timely transmission of the data;

10. If the contract provides for a sharing of interim profits by the managing general agent, and the managing general agent has the authority to determine the amount of the interim profits by establishing loss reserves or controlling claim payments, or in any other manner, interim profits will not be paid to the managing general agent on the lines of business written by the managing general agent until at least ninety-seven percent (97%) of the ultimate loss has been developed for those lines of business, based on an opinion of the actuary who certifies the adequacy of the loss reserves for the insurer;

11. The managing general agent shall not:

- a. bind reinsurance or retrocessions on behalf of the insurer, except that the managing general agent may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the insurer contains reinsurance underwriting guidelines including, for both reinsurance assumed and ceded:
 - (1) a list of reinsurers with which such automatic agreements are in effect,
 - (2) the coverages and amounts or percentages that may be reinsured, and
 - (3) commission schedules,
- b. commit the insurer to participate in insurance or reinsurance syndicates,
- c. appoint any agent or broker without assuring that the agent or broker is lawfully licensed to transact the type of insurance for which he is appointed,
- d. without prior approval of the insurer, pay or commit the insurer to pay a claim over a specified amount, net of reinsurance, which shall not exceed one percent (1%) of the insurer's policyholder's surplus as of December 31 of the last completed calendar year,
- e. collect any payment from a reinsurer or commit the insurer to any claim settlement with a reinsurer without prior approval of the insurer. If prior approval is given, a report shall be promptly forwarded to the insurer,
- f. permit its sub-agent or sub-broker to serve on the insurer's board of directors,
- g. jointly employ an individual who is employed with the insurer, or
- h. appoint a sub-managing general agent.

Added by Laws 1991, c. 134, § 4, eff. July 1, 1991. Amended by Laws 2002, c. 307, § 23, eff. Nov. 1, 2002.

§36-1475. Financial examination and on-site reviews - Binding authority for contracts - Notice of appointment or termination - Review of books and records - Appointments to board.

A. The insurer shall have on file an independent financial examination, in a form acceptable to the Insurance Commissioner, of each managing general agent with which it has done business.

B. The insurer shall periodically, at least semi-annually, conduct an on-site review of the underwriting and claims processing operations of the managing general agent.

C. Binding authority for all reinsurance contracts or participation in insurance or reinsurance syndicates shall rest with an officer of the insurer, who shall not be affiliated with the managing general agent.

D. Within thirty (30) days of entering into or termination of a contract with a managing general agent, the insurer shall provide written notification of such appointment or termination to the Insurance Commissioner. Notices of appointment of a managing general agent shall include:

1. A statement of duties which the applicant is expected to perform on behalf of the insurer;

2. The lines of insurance for which the applicant is to be authorized to act; and

3. Any other information the Commissioner may request.

E. An insurer shall review its books and records each quarter to determine if any agent or broker has become a managing general agent as defined in Section 2 of this act. If the insurer determines that an agent or broker has become a managing general agent, the insurer shall promptly notify the agent or broker and the Insurance Commissioner of such determination, and the insurer and agent or broker shall fully comply with the provisions of this act within thirty (30) days of such notification.

F. An insurer shall not appoint to its board of directors an officer, director, employee, sub-agent, sub-broker or controlling shareholder of its managing general agents. This subsection shall not apply to relationships governed by the insurance holding company act, Section 1651 et seq. of this title.

Added by Laws 1991, c. 134, § 5, eff. July 1, 1991.

§36-1476. Acts of managing general agent - Imputation to insurer.

The acts of the managing general agent are considered to be the acts of the insurer on whose behalf the agent is acting. A managing general agent may be examined as if the agent were the insurer.

Added by Laws 1991, c. 134, § 6, eff. July 1, 1991.

§36-1477. Violations - Penalties - Judicial review - Rights affected.

A. If the Insurance Commissioner finds, after a hearing conducted in accordance with Article II of the Administrative Procedures Act, that any person had violated any provision of the Managing General Agents Act or rules promulgated pursuant thereto, the Commissioner may order:

1. For each separate violation, a penalty in an amount of not less than One Hundred Dollars (\$100.00) nor more than Five Thousand Dollars (\$5,000.00) for each occurrence;

2. Revocation or suspension of the producer's license; and

3. The managing general agent to reimburse the insurer, the rehabilitator or the liquidator of the insurer for any losses incurred by the insurer which were caused by a violation of the Managing General Agents Act committed by the managing general agent.

B. The decision, determination or order of the Commissioner pursuant to subsection A of this section shall be subject to judicial review pursuant to the Administrative Procedures Act and any applicable insurance laws and regulations.

C. Nothing contained in this section shall affect the right of the Commissioner to impose any other penalties provided for in the Oklahoma Insurance Code.

D. Nothing contained in the Managing General Agents Act is intended to or shall, in any manner, limit or restrict the rights of policyholders, claimants and auditors.

E. No insurer may continue to utilize the services of a managing general agent on or after July 1, 1991, unless such utilization is in compliance with the Managing General Agents Act. Added by Laws 1991, c. 134, § 7, eff. July 1, 1991. Amended by Laws 2012, c. 44, § 5, eff. Nov. 1, 2012.

§36-1478. Rules and regulations.

The Insurance Commissioner may adopt reasonable rules and regulations for the implementation and administration of the provisions of this act.

Added by Laws 1991, c. 134, § 8, eff. July 1, 1991.

§36-1501. "Assets" defined.

In any determination of the financial condition of an insurer, there shall be allowed as assets only such assets as are owned by the insurer and which consist of:

1. Cash in the possession of the insurer, or in transit under its control, and including the true balance of any deposit in a solvent bank or trust company.

2. Investments, securities, properties and loans acquired or held in accordance with this Code, and in connection therewith the following items:

(a) Interest due or accrued on any bond or evidence of indebtedness which is not in default and which is not valued on a basis including accrued interest.

(b) Declared and unpaid dividends on stock and shares, unless such amount has otherwise been allowed as an asset.

(c) Interest due or accrued upon a collateral loan in an amount not to exceed one (1) year's interest thereon.

(d) Interest due or accrued on deposits in solvent banks and trust companies, and interest due or accrued on other assets, if such interest is in the judgment of the Insurance Commissioner a collectible asset.

(e) Interest due or accrued on a mortgage loan, in an amount not exceeding in any event the amount, if any, of the excess of the value of the property less delinquent taxes thereon over the unpaid principal; but in no event shall interest accrued for a period in excess of eighteen (18) months be allowed as an asset.

(f) Rent due or accrued on real property if such rent is not in arrears for more than three (3) months, and rent more than three (3) months in arrears if the payment of such rent be adequately secured by property held in the name of the tenant and conveyed to the insurer as collateral.

(g) The unaccrued portion of taxes paid prior to the due date on real property.

3. Premium notes, policy loans, and other policy assets and liens on policies and certificates of life insurance and annuity contracts and accrued interest thereon, in an amount not exceeding the legal reserve and other policy liabilities carried on each individual policy.

4. The net amount of uncollected and deferred premiums and annuity considerations in the case of a life insurer.

5. Premiums in the course of collection, other than for life insurance, not more than three (3) months past due, less commissions payable thereon. The foregoing limitation shall not apply to premiums payable directly or indirectly by the United States government or by any of its instrumentalities.

6. Installment premiums other than life insurance premiums to the extent of the unearned premium reserves carried thereon.

7. Notes and like written obligations not past due, taken for premiums other than life insurance premiums, on policies permitted to be issued on such basis, to the extent of the unearned premium reserves carried thereon.

8. The full amount of reinsurance recoverable by a ceding insurer from a solvent reinsurer and which reinsurance is authorized under Section 711 of Article 7 (Kinds of Insurance; Reinsurance; Limits of Risk).

9. Amounts receivable by an assuming insurer representing funds withheld by a solvent ceding insurer under a reinsurance treaty.

10. Deposits or equities recoverable from underwriting associations, syndicates and reinsurance funds, or from any suspended banking institution, to the extent deemed by the Insurance Commissioner available for the payment of losses and claims and at values to be determined by him.

11. All assets, whether or not consistent with the provisions of this section, as may be allowed pursuant to the annual statement form approved by the national association of insurance commissioners for the kinds of insurance to be reported upon therein.

12. Rebates determined and accrued pursuant to Section 2 of this act.

13. Other assets, not inconsistent with the provisions of this section, deemed by the Insurance Commissioner to be available for the payment of losses and claims, at values to be determined by the Commissioner.

Added by Laws 1957, p. 280, § 1501, operative July 1, 1957. Amended by Laws 2002, c. 31, § 1, emerg. eff. April 10, 2002.

§36-1502. Assets as deductions from liabilities.

Assets may be allowable as deductions from corresponding liabilities, and liabilities may be charged as deductions from assets, and deductions from assets may be charged as liabilities, in accordance with the form of annual statement applicable to such insurer as prescribed by the Insurance Commissioner, or otherwise in his discretion.

Laws 1957, p. 281, § 1502.

§36-1503. Assets not allowed as deductions from liabilities.

In addition to assets impliedly excluded by the provisions of Section 1501 of this article, the following expressly shall not be allowed as assets in any determination of the financial condition of an insurer:

1. Trade names and other like intangible assets, excluding good will.

2. Advances to officers (other than policy loans) whether secured or not, and advances to employees, agents and other persons on personal security only.

3. Stock of such insurer, owned by it, or any equity therein or loans secured thereby, or any proportionate interest in such stock acquired or held through the ownership by such insurer of an interest in another firm, corporation or business unit.

4. Furniture, fixtures, furnishings, safes, vehicles, libraries, stationery, literature and supplies, except in the case of title insurers such materials and plants as the insurer is expressly authorized to invest in under Article 50 (Title Insurers) of this Code and except, in the case of any insurer, such personal property as the insurer is permitted to hold pursuant to Article 16

(Investments) of this Code, or which is reasonably necessary for the maintenance and operation of real estate lawfully acquired and held by the insurer other than real estate used by it for home office, branch office and similar purposes.

5. The amount, if any, by which the aggregate book value of investments as carried in the ledger assets of the insurer exceeds the aggregate value thereof as determined under this Code. Added by Laws 1957, p. 281, § 1503, operative July 1, 1957. Amended by Laws 2004, c. 334, § 41, emerg. eff. May 25, 2004.

§36-1504. Reporting assets not allowed.

All assets not allowed and all other assets of doubtful value or character included as assets in any statement by an insurer to the Insurance Commissioner, or in any examiner's report to said Commissioner, shall also be reported, to the extent of the value disallowed, as deductions from the gross assets of such insurer. Laws 1957, p. 281, § 1504.

§36-1505. Liabilities - Mandatory securities valuation reserves.

A. In any determination of the financial condition of an insurer, capital stock and liabilities to be charged against its assets shall include:

1. The amount of its capital stock outstanding, if any.

2. The amount, estimated consistent with the provisions of this Code, necessary to pay all of its unpaid losses and claims incurred on or prior to the date of statement, whether reported or unreported, together with the expenses of adjustment or settlement thereof.

3. With reference to life and disability insurance and annuity contracts:

(a) The amount of reserves on life insurance policies and annuity contracts in force, valued according to the tables of mortality, rates of interest, and methods adopted pursuant to this Code which are applicable thereto,

(b) Reserves for disability benefits, for both active and disabled lives,

(c) Reserves for accidental death benefits, and

(d) Any additional reserves which may be required by the Insurance Commissioner consistent with practice formulated or approved by the National Association of Insurance Commissioners, on account of such insurance.

4. With reference to insurance other than specified in subsection 3 this section, and other than title insurance, the amount of reserves equal to the unearned portions of the gross premiums charged on policies in force, computed in accordance with this article.

5. Taxes, expenses and other obligations due or accrued at the date of the statement.

B. All life insurance companies and fraternal benefit societies shall establish and maintain mandatory securities valuation reserves in accordance with the guidelines established by the National Association of Insurance Commissioners. Life insurance companies without mandatory securities valuation reserves as of December 31, 1989, shall begin accruing twenty percent (20%) of the mandatory securities value reserves per year and have reserves in accordance with the required guidelines within five (5) years. Laws 1957, p. 281, § 1505.

§36-1506. Unearned premium reserve.

A. With reference to insurance against loss or damage to property (except as provided in Section 1507 of this article) and with reference to all general casualty insurance, and surety insurance, every insurer shall maintain an unearned premium reserve on all policies in force.

B. The Insurance Commissioner may require that such reserves shall be equal to the unearned portions of the gross premiums in force after deducting reinsurance in solvent insurers as computed on each respective risk from the policy's date of issue. If the Insurance Commissioner does not so require, the portions of the gross premium in force, less reinsurance in solvent insurers to be held as a premium reserve, shall be computed according to the following table:

Term for Which Policy Was Written	Reserve for Unearned Premium
1 Year or less	1/2
2 Years	1st year 3/4 2nd year 1/4
3 Years	1st year 5/6 2nd year 1/2 3rd year 1/6
4 Years	1st year 7/8 2nd year 5/8 3rd year 3/8 4th year 1/8
5 Years	1st year 9/10 2nd year 7/10 3rd year 1/2 4th year 3/10 5th year 1/10
Over 5 years	pro rata

C. Unearned premium reserves on policies written for an intermediate period shall be calculated at the succeeding longer period or on a monthly pro rata basis.

D. In lieu of computation according to the foregoing table, all of such reserves may be computed, at the option of the insurer, on a monthly or more frequent pro rata basis.

E. After adopting a method for computing such reserve, an insurer shall not change methods without approval of the Insurance Commissioner.

F. This section does not apply to title insurance.
Laws 1957, p. 282, § 1506.

§36-1507. Unearned premium reserve for marine insurance.

With reference to marine insurance, premiums on trip risks not terminated shall be deemed unearned, and the Insurance Commissioner may require the insurer to carry a reserve thereon equal to one hundred percent (100%) on trip risks written during the month ended as of the date of statement.

Laws 1957, p. 282, § 1507.

§36-1508. Reserves for accident and health insurance.

For all accident and health policies the insurer shall maintain an active life reserve which shall place a sound value on its liabilities under such policies and which shall not be less than the reserve according to the standards set forth in regulations issued by the Commissioner and, in no event, less than the pro rata gross unearned premium reserve for such policies.

Laws 1957, p. 282, § 1508.

§36-1509. Increase of inadequate reserves - Present value discounting - Annual actuarial opinions - Investment limitations - Unusual dividend or benefit payments.

A. If the Insurance Commissioner determines in writing that an insurer's unearned premium reserve, however computed, is inadequate, the Commissioner may require the insurer to compute the reserve or any part thereof according to any other method or methods as are prescribed in this article.

B. If the loss experience of an insurer shows that its loss reserves, however estimated, are inadequate, the Commissioner, in writing, shall require the insurer to maintain loss reserves in an increased amount as is needed to make them adequate.

C. 1. Insurers shall not use present value discounting for computing reserves for property and casualty insurance, except for workers' compensation carriers and physicians' and hospitals' professional liability insurance written on an occurrence basis. Workers' compensation carriers may use present value discounting at a rate of four percent (4%) for disability and death claims.

Property and casualty insurers which elect to use present value discounting for computing reserves on physicians' and hospitals' professional liability insurance shall file initially, and thereafter annually, an actuarial opinion certifying to the adequacy of such reserves which shall include an analysis of the propriety of loss payout patterns, interest rate assumptions used in developing the discount and the adequacy of the insurer's rates. Additionally, the actuary shall consider the quality and liquidity of the insurer's assets and the nature and extent of the insurer's reinsurance program. In no event shall the interest rate used to compute the discounted reserves exceed the insurer's average yield on invested assets for the year, less one percent (1%).

2. Annual actuarial opinions required pursuant to this subsection shall be filed by the insurer on or before the first day of April. All actuarial opinions shall be from an independent actuary with membership in the American Academy of Actuaries or The Casualty Actuarial Society.

3. Except for workers' compensation insurance carriers, insurers discounting reserves pursuant to this subsection shall invest and maintain their funds only in cash; securities described in the following sections of this Code:

- a. Section 1607 (securities of or guaranteed by the United States),
- b. Section 1608 (state and Canadian public obligations),
- c. Section 1609 (county, municipal and district obligations),
- d. Section 1610 (public improvement bonds),
- e. Section 1611 (obligations payable from public utility revenues) limited to issues which, at time of purchase, are rated A or better by Standard and Poor's Bond Guide or Moody's Bond Record,
- f. Section 1614 (corporate obligations) limited to issues which, at time of purchase, are rated A or better by Standard and Poor's Bond Guide or Moody's Bond Record, and
- g. Section 1620 (deposits, banks, savings and loans); and any other investment specifically approved by the Commissioner.

4. This subsection applies to reserves established in connection with incidents of loss occurring on or after January 1, 1989. The investment limitations prescribed by this subsection shall be applicable on or after January 1, 1989.

D. During any period of reserve strengthening mandated by the Commissioner pursuant to the provisions of this section, no insurer shall pay dividends or other benefits which would not be normal payments under the terms of a policy to any stockholder or policyholder of such insurer and such insurer shall be subject to

any additional reasonable restrictions as the Commissioner shall deem prudent.

E. Insurers shall report, on a form prescribed by the Commissioner and filed with their annual statement, all funds collected through policy fees or assessments which were collected in response to a written request to increase inadequate reserves from the Commissioner made pursuant to the provisions of this section.

F. 1. Insurers domiciled in this state that are issuing policies of medical professional liability insurance to physicians, allied health care professionals and health care institutions, as defined by Section 2202 of this title, on July 1, 2004, are granted a moratorium on the applicability of any provisions of the laws of this state that require the maintenance of adequate reserves. The moratorium shall be in effect until December 31, 2008.

2. Any insurer eligible to utilize the moratorium provided by this section that elects to utilize the moratorium shall notify the Commissioner in writing of the election prior to the application of the moratorium to the insurer.

3. Any policy issued by an insurer utilizing the moratorium provided by this section shall, during the moratorium period, contain the following notice in ten-point type on the front page and the declaration page:

NOTICE

The insurer is not subject to the insurance laws and regulations related to maintenance of reserves and surplus.

Added by Laws 1957, p. 282, § 1509, operative July 1, 1957. Amended by Laws 1988, c. 151, § 1, eff. Nov. 1, 1988; Laws 1990, c. 227, § 2, emerg. eff. May 18, 1990; Laws 1996, c. 363, § 15, eff. Nov. 1, 1996; Laws 2004, c. 368, § 56, eff. July 1, 2004; Laws 2005, c. 44, § 1, eff. Nov. 1, 2005.

§36-1509.1. Confidentiality of information.

All work papers, recorded information, documents and copies of materials associated with, produced, obtained by or disclosed to the Insurance Commissioner or any other person in the course of review or analysis pursuant to Sections 1801 through 1938 of this title shall be given confidential treatment by the Commissioner and may not be made public by the Commissioner or any other person who obtained the information in the course of the review or analysis, except to the extent provided in Sections 1801 through 1938 of this title, unless prior written consent of the company to which it pertains has been obtained. The confidentiality and protection from discovery by subpoena provided for in this paragraph shall not be construed to be extended to identical, similar or other related documents or information or to the work papers that are not deemed to be in the possession, custody or control of the Commissioner.

Added by Laws 2010, c. 356, § 6, eff. Nov. 1, 2010. Amended by Laws 2012, c. 149, § 4, eff. Nov. 1, 2012.

§36-1510. Definitions - Valuation law - Life - Exemption - Conflict.

A. Definitions. For the purposes of this section the following definitions shall apply on or after the operative date of the valuation manual:

1. "Accident and health insurance" means contracts that incorporate morbidity risk and provide protection against economic loss resulting from accident, sickness, or medical conditions and as may be specified in the valuation manual;

2. "Company" means an entity which:

(a) has written, issued, or reinsured life insurance contracts, accident and health insurance contracts, or deposit-type contracts in this state and has at least one such policy in force or on claim, or

(b) has written, issued, or reinsured life insurance contracts, accident and health insurance contracts, or deposit-type contracts in any state and is required to hold a certificate of authority to write life insurance, accident and health insurance, or deposit-type contracts in this state;

3. "Deposit-type contract" means contracts that do not incorporate mortality or morbidity risks and as may be specified in the valuation manual;

4. "Life insurance" means contracts that incorporate mortality risk, including annuity and pure endowment contracts, and as may be specified in the valuation manual;

5. "NAIC" means the National Association of Insurance Commissioners;

6. "Policyholder behavior" means any action a policyholder, contract holder or any other person with the right to elect options, such as a certificate holder, may take under a policy or contract subject to this section, including, but not limited to, lapse, withdrawal, transfer, deposit, premium payment, loan, annuitization, or benefit elections prescribed by the policy or contract but excluding events of mortality or morbidity that result in benefits prescribed in their essential aspects by the terms of the policy or contract;

7. "Principle-based valuation" means a reserve valuation that uses one or more methods or one or more assumptions determined by the insurer and is required to comply with subsection Q of this section as specified in the valuation manual;

8. "Tail risk" means a risk that occurs either where the frequency of low probability events is higher than expected under a

normal probability distribution or where there are observed events of very significant size or magnitude; and

9. "Valuation manual" means the manual of valuation instructions adopted by the NAIC as specified in this section or as subsequently amended.

B. Reserve Valuation.

1. Policies and Contracts Issued Prior to the Operative Date of the Valuation Manual.

(a) The Insurance Commissioner shall annually make calculations of all outstanding policies, additions thereto, unpaid dividends, annuity and pure endowment contracts and all other obligations of every life insurance corporation doing business in this state issued prior to the operative date of the valuation manual. In lieu of the valuation of the reserves required of a foreign or alien company, the Insurance Commissioner may accept a valuation made, or caused to be made, by the insurance supervisory official of any state or other jurisdiction when the valuation complies with the minimum standard provided in this section.

(b) The provisions set forth in subsections C, D, E, F, G, H, J, K, L, M, N and O of this section shall apply to all policies and contracts, as appropriate, subject to this section issued prior to the operative date of the valuation manual and the provisions set forth in subsections P and Q of this section shall not apply to any such policies and contracts.

2. Policies and Contracts Issued On and After the Operative Date of the Valuation Manual.

(a) The Insurance Commissioner shall annually make calculations of all outstanding policies, additions thereto, unpaid dividends, annuity and pure endowment contracts, accident and health contracts, deposit-type contracts, and all other obligations of every company doing business in this state issued on or after the operative date of the valuation manual. In lieu of the valuation of the reserves required of a foreign or alien company, the Insurance Commissioner may accept a valuation made, or caused to be made, by the insurance supervisory official of any state or other jurisdiction when the valuation complies with the minimum standard provided in this section.

(b) The provisions set forth in subsections P and Q of this section shall apply to all policies and contracts issued on or after the operative date of the valuation manual.

C. 1. Valuations made by the Insurance Commissioner shall be made upon the net premium basis. In the case of alien insurers, such valuation shall be limited to its United States business. The legal minimum standard for valuation of contracts issued before the first day of January, 1910, shall be the Actuaries or Combined Experience Table of Mortality, with interest at four percent (4%) per annum, and for valuation of contracts issued on or after said date and before June 6, 1949, shall be the American Experience Table of Mortality, or the American Men Table of Mortality, with interest at three and one-half percent (3 1/2%) per annum. Except as otherwise provided policies issued on or after the operative date of paragraph 4 of subsection I of Section 4029 of this title, policies issued on or after June 6, 1949, shall be valued, collectively as to all such policies or severally as to policies of any plan or form at the option of the company according to the American Experience Table of Mortality, the American Men Table of Mortality, the Commissioners 1941 Standard Ordinary Mortality Table or on and after July 1, 1962, the Commissioners 1958 Standard Ordinary Mortality Table for policies of ordinary insurance, and the Standard Industrial Mortality Table (1907), or the 1941 Standard Industrial Mortality Table or the Commissioners 1961 Standard Industrial Mortality Table for policies of industrial insurance, with interest at not more than three and one-half percent (3 1/2%) per annum, or four percent (4%) per annum in the case of policies issued on or after April 11, 1974, and prior to March 17, 1978, and four and one-half percent (4 1/2%) per annum for policies issued on or after March 17, 1978; provided, however, that policies issued to substandard risks or other special classes may be valued according to such other mortality tables, with interest at not more than three and one-half percent (3 1/2%) per annum, or four percent (4%) per annum in the case of policies issued on or after April 11, 1974, and prior to March 17, 1978, and four and one-half percent (4 1/2%) per annum for policies issued on or after March 17, 1978, as may be approved by the Insurance Commissioner.

2. For individual annuity and pure endowment contracts, excluding any disability and accidental death benefits in such policies, the 1937 Standard Annuity Mortality Table, or, at the option of the company, the Annuity Mortality Table for 1949, Ultimate, or any modification of either of these tables approved by the Commissioner.

3. For group annuity and pure endowment contracts, excluding any disability and accidental death benefits in such policies, the Group Annuity Mortality Table for 1951, any modification of such table approved by the Commissioner, or, at the option of the company, any of the tables or modifications of tables specified for individual annuity and pure endowment contracts.

4. The mortality table used in determining the minimum standard for the valuation of ordinary life insurance policies issued on or after the operative date of paragraph 4 of subsection I of Section 4029 of this title shall be (i) the Commissioners 1980 Standard Ordinary Mortality Table, or (ii) at the election of the company for any one or more specified plans of life insurance, the Commissioners 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors, or (iii) any ordinary mortality table, adopted after 1980 by the NAIC, that is approved by regulation promulgated by the Commissioner for use in determining the minimum standard of valuation for such policies.

5. Except as provided in subsection D of this section, the minimum standard of valuation for individual annuity and pure endowment contracts issued on or after the operative date of this section and for annuities and pure endowments purchased on or after such operative date under group annuity and pure endowment contracts shall be the Commissioner's reserve valuation methods defined in subsections G and H of this section and the following tables and interest rates:

- (a) For individual annuity and pure endowment contracts issued prior to August 29, 1977, excluding any disability and accidental death benefit in such contracts, the 1971 Individual Annuity Mortality Table, or any modification of this table approved by the Commissioner, and six percent (6%) interest for single premium immediate annuity contracts, and four percent (4%) interest for all other individual annuity and pure endowment contracts,
- (b) For individual single premium immediate annuity contracts issued on or after August 29, 1977, excluding any disability and accidental death benefits in such contracts, the 1971 Individual Annuity Mortality Table or any individual annuity mortality table adopted after 1980 by the NAIC that is approved by regulation promulgated by the Commissioner for use in determining the minimum standard of valuation for such contracts, or any modification of these tables approved by the Commissioner, and seven and one-half percent (7 1/2%) interest,
- (c) For individual annuity and pure endowment contracts issued on or after August 29, 1977, other than single premium immediate annuity contracts, excluding any disability and accidental death benefits in such contracts, the 1971 Individual Annuity Mortality Table or any individual annuity mortality table adopted after 1980 by the NAIC that is approved by regulation promulgated by the Commissioner for use in determining

the minimum standard of valuation for such contracts, or any modification of these tables approved by the Commissioner, and five and one-half percent (5 1/2%) interest for single premium deferred annuity and pure endowment contracts and four and one-half percent (4 1/2%) interest for all other such individual annuity and pure endowment contracts,

- (d) For all annuities and pure endowments purchased prior to August 29, 1977, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under such contracts, the 1971 Group Annuity Mortality Table, or any modification of this table approved by the Commissioner, and six percent (6%) interest, and
- (e) For all annuities and pure endowments purchased on or after August 29, 1977, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under such contracts, the 1971 Group Annuity Mortality Table or any group annuity mortality table adopted after 1980 by the NAIC that is approved by regulation promulgated by the Commissioner for use in determining the minimum standard of valuation for such annuities and pure endowments, or any modification of these tables approved by the Commissioner, and seven and one-half percent (7 1/2%) interest.

After June 14, 1973, any company may file with the Commissioner a written notice of its election to comply with the provisions of this section after a specified date before January 1, 1985, which shall be the operative date of this section for such company, provided, a company may elect a different operative date for individual annuity and pure endowment contracts from that elected for group annuity and pure endowment contracts. If a company makes no such election, the operative date of this section for such company shall be January 1, 1985.

D. 1. The interest rates used in determining the minimum standard for the valuation of all life insurance policies issued in a particular calendar year on or after the operative date of paragraph 4 of subsection I of Section 4029 of this title shall be the calendar year statutory valuation interest rates as defined in this section.

2. The interest rates used in determining the minimum standard valuation of individual annuity and pure endowment contracts issued in a particular calendar year on or after January 1, 1985, and annuities and pure endowments purchased in a particular calendar year on or after January 1, 1985, under group annuity and pure

endowment contracts shall be the calendar year statutory valuation interest rates as defined in this section.

E. 1. The calendar year statutory valuation interest rates, I, shall be determined as follows and the results rounded to the nearest one-fourth of one percent (1/4 of 1%):

(a) For life insurance,

$$I = .03 + W (R_a - .03) + (W/2) (R_b - .09)$$

where R_a is the lesser of R and $.09$, R_b is the greater of R and $.09$, R is the reference interest rate defined in this section, and W is the weighting factor defined in this section,

(b) For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and from guaranteed interest contracts with cash settlement options,

$$I = .03 + W(r - .03)$$

where R_1 is the lesser of R and $.09$, R_2 is the greater of R and $.09$, R is the reference interest rate defined in this section, and W is the weighting factor defined in this section,

(c) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on an issue year basis, except as stated in subparagraph (b) of this paragraph, the formula for life insurance stated in subparagraph (a) of this paragraph shall apply to annuities and guaranteed interest contracts with guarantee durations in excess of ten (10) years and the formula for single premium immediate annuities stated in subparagraph (b) of this paragraph shall apply to annuities and guaranteed interest contracts with guarantee duration of ten (10) years or less,

(d) For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the formula for single premium immediate annuities stated in subparagraph (b) of this paragraph shall apply, and

(e) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, the formula for single premium immediate annuities stated in subparagraph (b) of this paragraph shall apply.

2. However, if the calendar year statutory valuation interest rate for any life insurance policies issued in any calendar year determined without reference to this sentence differs from the corresponding actual rate for similar policies issued in the

immediately preceding calendar year by less than one-half of one percent (1/2 of 1%), the calendar year statutory valuation interest rate for such life insurance policies shall be equal to the corresponding actual rate for the immediately preceding calendar year. For purposes of applying the immediately preceding sentence, the calendar year statutory valuation interest rate for life insurance policies issued in a calendar year shall be determined for 1980, using the reference interest rate defined for 1979, and shall be determined for each subsequent calendar year.

F. 1. The weighting factors referred to in the formulas stated above are given in the following table:

(a) Weighting Factors for Life Insurance:

Guarantee Duration (Years)	Weighting Factors
10 or less	.50
More than 10, but not more than 20	.45
More than 20	.35

For life insurance, the guarantee duration is the maximum number of years the life insurance can remain in force on a basis guaranteed in the policy or under options to convert to plans of life insurance with premium rates or nonforfeiture values or both which are guaranteed in the original policy.

(b) Weighting factor for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options: .80

(c) Weighting factors for other annuities and for guaranteed interest contracts, except as stated in subparagraph (b) of this paragraph, shall be as specified in tables (1), (2) and (3) below, according to the rules and definitions in (4) and (5) below:

(1) For annuities and guaranteed interest contracts valued on an issue year basis:

Guarantee Duration (Years)	Weighting Factor for Plan Type		
	A	B	C
5 or less	.80	.60	.50
More than 5, but not more than 10	.75	.60	.50
More than 10, but not more than 20	.65	.50	.45
More than 20	.45	.35	.35

- (2) For annuities and guaranteed interest contracts valued on a change in fund basis, the factors shown in (1) above increased by:

Plan Type		
A	B	C
.15	.25	.05

- (3) For annuities and guaranteed interest contracts valued on an issue year basis (other than those with no cash settlement options) which do not guarantee interest on considerations received more than one (1) year after issue or purchase and for annuities and guaranteed interest contracts valued on a change in fund basis which do not guarantee interest rates on considerations received more than twelve (12) months beyond the valuation date, the factors shown in (1) or derived in (2) increased by:

Plan Type		
A	B	C
.05	.05	.05

- (4) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the guarantee duration is the number of years for which the contract guarantees interest rates in excess of the calendar year statutory valuation interest rate for life insurance policies with guarantee duration in excess of twenty (20) years. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the guarantee duration is the number of years from the date of issue or date of purchase to the date annuity benefits are scheduled to commence.

- (5) Plan type as used in the above tables is defined as follows:

Plan Type A: At any time policyholder may withdraw funds only (1) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company, or (2) without such adjustment but in installments over five (5) years or more, or (3) as an immediate life annuity, or (4) no withdrawal permitted.

Plan Type B: Before expiration of the interest rate guarantee, policyholder may withdraw funds only (1) with adjustment to reflect changes in

interest rates or asset values since receipt of the funds by the insurance company, or (2) without such adjustment but in installments over five (5) years or more, or (3) no withdrawal permitted. At the end of interest rate guarantee, funds may be withdrawn without such adjustment in a single sum or installments over less than five (5) years.

Plan Type C: Policyholder may withdraw funds before expiration of interest rate guarantee in a single sum or installments over less than five (5) years either (1) without adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company, or (2) subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund.

2. A company may elect to value guaranteed interest contracts with cash settlement options and annuities with cash settlement options on either an issue year basis or on a change in fund basis. Guaranteed interest contracts with no cash settlement options and other annuities with no cash settlement options shall be valued on an issue year basis. As used in this section, an issue year basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard for the entire duration of the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of issue or year of purchase of the annuity or guaranteed interest contract, and the change in fund basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard applicable to each change in the fund held under the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of the change in the fund.

G. 1. The reference interest rate referred to above shall be defined as follows:

- (a) For life insurance, the lesser of the average over a period of thirty-six (36) months and the average over a period of twelve (12) months, ending on June 30 of the calendar year next preceding the year of issue, of Moody's Corporate Bond Yield Average - Monthly Average Corporates, as published by Moody's Investors Service, Inc.,
- (b) For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the average over a period of twelve (12)

months, ending on June 30 of the calendar year of issue or year of purchase of the Monthly Average of the Composite Yield on Seasoned Corporate Bonds, as published by Moody's Investors Service, Inc.,

- (c) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on an issue year basis, except as stated in subparagraph (b) of this paragraph, with guarantee duration in excess of ten (10) years, the lesser of the average over a period of thirty-six (36) months and the average over a period of twelve (12) months, ending on June 30 of the calendar year of issue or purchase, of the Monthly Average of the Composite Yield on Seasoned Corporate Bonds, as published by Moody's Investors Service, Inc.,
- (d) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on an issue year basis, except as stated in subparagraph (b) of this paragraph, with guarantee duration of ten (10) years or less, the average over a period of twelve (12) months, ending on June 30 of the calendar year of issue or purchase, of the Monthly Average of the Composite Yield on Seasoned Corporate Bonds, as published by Moody's Investors Service, Inc.,
- (e) For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the average over a period of twelve (12) months, ending on June 30 of the calendar year of issue or purchase, of the Monthly Average of the Composite Yield on Seasoned Corporate Bonds, as published by Moody's Investors Service, Inc., and
- (f) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, except as stated in subparagraph (b) of this paragraph, the average over a period of twelve (12) months, ending on June 30 of the calendar year of the change in the fund, of the Monthly Average of the Composite Yield on Seasoned Corporate Bonds, as published by Moody's Investors Service, Inc.

H. In the event that the Moody's Corporate Bond Yield Average - Monthly Average Corporates is no longer published by Moody's Investors Service, Inc., or in the event that the NAIC determines that the Moody's Corporate Bond Yield Average - Monthly Average Corporates as published by Moody's Investors Service, Inc., is no longer appropriate for the determination of the reference interest

rate, then an alternative method for determination of the reference interest rate, which is adopted by the NAIC and approved by regulation promulgated by the Commissioner, may be substituted.

I. The Commissioner may vary the standards of interest and mortality in particular cases of invalid life and other extra hazards and value policies in groups, use approximate averages for fractions of a year and otherwise, and accept the valuation of the Department of Insurance of any other state or country, if made upon a basis and according to standards not lower than herein required or authorized, in place of the valuation herein required.

J. If in any contract year the gross premium charged by any company on any policy or contract is less than the valuation net premium for the policy or contract calculated by the method used in computing the reserve liability thereon but using the minimum valuation standards of mortality and rate of interest, the minimum reserve required for such policy or contract shall be the greater of either the reserve calculated according to the mortality table, rate of interest and method actually used for such policy or contract, or the reserve calculated by the method actually used for such policy or contract, but using the minimum valuation standards of mortality and rate of interest and replacing the valuation net premium by the actual gross premium in each contract year for which the valuation net premium exceeds the actual gross premium. The minimum valuation standards of mortality and rate of interest referred to in this subsection are those standards stated in this section.

Provided that for any life insurance policy issued on or after January 1, 1986, for which the gross premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess, and which provides an endowment benefit or a cash surrender value or a combination thereof in an amount greater than such excess premium, the foregoing provisions of this subsection shall be applied as if the method actually used in calculating the reserve for such policy were the method described in paragraph 2 of subsection L of this section, ignoring subparagraph (c) of that paragraph. The minimum reserve at each policy anniversary of such a policy shall be the greater of the minimum reserve calculated in accordance with paragraph 2 of subsection L of this section, including subparagraph (c) of that paragraph, and the minimum reserve calculated in accordance with this subsection.

K. Term Insurance.

Policies issued by life insurance companies doing business in this state may provide for not more than one (1) year preliminary term insurance, purchased by the whole or part of the premium to be received during the first policy year, under the conditions prescribed in this section.

L. Reserves.

1. Reserves on policies of ordinary insurance which are valued in accordance with the American Experience Table of Mortality, or the American Men Table of Mortality, and policies of industrial insurance which are valued in accordance with the Standard Industrial Mortality Table (1907), which are issued on or after June 6, 1949, may be computed as follows: If the premium charged for term insurance under a limited payment life preliminary term policy providing for the payment of all premiums thereon in less than twenty (20) years from the date of the policy or under an endowment preliminary term policy, exceeds that charged for life insurance, under twenty-year payment life preliminary term policies of the same company, the reserve thereon at the end of any year, including the first, shall not be less than the reserve on a twenty-payment life preliminary term policy issued in the same year and at the same age, together with an amount which shall be equivalent to the accumulation of a net level premium sufficient to provide for a pure endowment at the end of the premium payment period equal to the difference between the value at the end of such period of such a twenty-payment life preliminary term policy and the full reserve at such time of such a limited payment life or endowment policy. The premium payment period is the period during which premiums are concurrently payable under such twenty-payment life preliminary term policy and such limited payment life or endowment policy. Any policy valued in accordance with this paragraph shall specify the mortality table, rate of interest, and method used in calculating the reserves on the policy.

2. Reserves on policies of ordinary insurance which are valued in accordance with the Commissioners 1941 Standard Ordinary Mortality Table, the Commissioners 1958 Standard Ordinary Mortality Table, or the Commissioners 1980 Standard Ordinary Mortality Table, policies of industrial insurance which are valued in accordance with the 1941 Standard Industrial Mortality Table or the Commissioners 1961 Standard Industrial Mortality Table and policies valued in accordance with any substandard mortality table approved by the Commissioner pursuant to this section, issued on or after June 6, 1949, may be computed in accordance with the Commissioners Reserve Valuation method, defined as follows: Reserves for the life insurance and endowment benefits of policies providing for a uniform amount of insurance and requiring the payment of uniform premiums shall be the excess, if any, of the present value, at the date of valuation, of such future guaranteed benefits provided for by such policies, over the then present value of any future modified net premiums therefor. The modified net premiums for any such policy shall be such uniform percentage of the respective contract premiums for such benefits that the present value, at the date of issue of the policy, of all such modified net premiums shall be equal to the sum of the then present value of such benefits provided for by the

policy and the excess of subparagraph (a) over subparagraph (b) as follows:

- (a) a net level annual premium equal to the present value, at the date of issue, of such benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of one per annum payable on the first and each subsequent anniversary of such policy on which a premium falls due; provided, however, that such level annual premium shall not exceed the net level annual premium on the nineteen-year premium whole life plan for insurance of the same amount at the age one (1) year higher than the age at issue of such policy,
- (b) a net one-year term premium for such benefits provided for in the first policy year, and
- (c) provided that for any life insurance policy issued on or after January 1, 1986, for which the contract premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess and which provides an endowment benefit or a cash surrender value or a combination thereof in an amount greater than such excess premium, the reserve according to the commissioners reserve valuation method as of any policy anniversary occurring on or before the assumed ending date defined herein as the first policy anniversary on which the sum of any endowment benefit and any cash surrender value then available is greater than such excess premium shall, except as otherwise provided in subsection J of this section, be the greater of the reserve as of such policy anniversary calculated as described in this paragraph and the reserve as of such policy anniversary calculated as described in subparagraph (a) of this paragraph, but with (i) the value defined in subparagraph (a) of that paragraph being reduced by fifteen percent (15%) of the amount of such excess first-year premium, (ii) all present values of benefits and premiums being determined without reference to premiums or benefits provided for by the policy after the assumed ending date, (iii) the policy being assumed to mature on such date as an endowment, and (iv) the cash surrender value provided on such date being considered as an endowment benefit. In making the above comparison, the mortality and interest bases stated in this section shall be used.

Reserves for life insurance policies providing for a varying amount of insurance or requiring the payment of varying premiums shall be calculated by a method consistent with the principles of paragraph 2 of this subsection, provided that any extra premiums charged because of impairments or special hazards shall be disregarded in the determination of modified net premiums. All modified net premiums and present values referred to in this section, except those based on sex-distinct mortality tables, may be calculated according to an age not more than six (6) years younger than the actual age of the insured in the case of any category of ordinary policies issued on female risks.

M. 1. Reserves on policies of any category may be computed, at the option of the company, according to any valuation standard which produces greater aggregate reserves than those computed according to the minimum standard provided in this section.

2. In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurance company based on then estimates of future experience, or in the case of any plan of life insurance or annuity which is of such a nature that the minimum reserves cannot be determined by the methods described in subsections C, I, J, K, and N of this section, the reserves which are held under any such plan must:

- (a) be appropriate in relation to the benefits and the pattern of premiums for that plan, and
- (b) be computed by a method which is consistent with the principles of this Standard Valuation Law,

as determined by regulations promulgated by the Commissioner.

N. This section shall apply to all annuity and pure endowment contracts other than group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code, as now or hereafter amended.

Reserves according to the Commissioners Annuity Reserve method for benefits under annuity or pure endowment contracts, excluding any disability and accidental death benefits in such contracts, shall be the greatest of the respective excesses of the present values, at the date of valuation, of the future guaranteed benefits, including guaranteed nonforfeiture benefits, provided for by such contracts at the end of each respective contract year, over the present value, at the date of valuation, of any future valuation considerations derived from future gross considerations, required by the terms of such contract, that become payable prior to the end of such respective contract year. The future guaranteed benefits shall

be determined by using the mortality table, if any, and the interest rate, or rates, specified in such contracts for determining guaranteed benefits. The valuation considerations are the portions of the respective gross considerations applied under the terms of such contracts to determine nonforfeiture values.

O. For accident and health insurance contracts issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under paragraph 2 of subsection B of this section. For accident and health insurance contracts issued prior to the operative date of the valuation manual, the minimum standard of valuation is the standard adopted by the commissioner by rule.

P. Valuation Manual for Policies Issued On or After the Operative Date of the Valuation Manual.

1. For policies issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under paragraph 2 of subsection B of this section, except as provided under paragraph 5 or 7 of this subsection.

2. The operative date of the valuation manual is January 1 of the first calendar year following the first July 1 as of which all of the following have occurred:

- (a) the valuation manual has been adopted by the NAIC by an affirmative vote of at least forty-two members, or three-fourths (3/4) of the members voting, whichever is greater,
- (b) the Standard Valuation Law, as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by states representing greater than seventy-five percent (75%) of the direct premiums written as reported in the following annual statements submitted for 2008: life, accident and health annual statements; health annual statements; or fraternal annual statements, and
- (c) the Standard Valuation Law, as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by at least forty-two of the following fifty-five jurisdictions: the fifty states of the United States, American Samoa, the American Virgin Islands, the District of Columbia, Guam, and Puerto Rico.

3. Unless a change in the valuation manual specifies a later effective date, changes to the valuation manual shall be effective on January 1 following the date when all of the following have occurred:

- (a) the change to the valuation manual has been adopted by the NAIC by an affirmative vote representing:

- (1) at least three-fourths (3/4) of the members of the NAIC voting, but not less than a majority of the total membership, and
 - (2) members of the NAIC representing jurisdictions totaling greater than seventy-five percent (75%) of the direct premiums written as reported in the following annual statements most recently available prior to the vote in division (1) of this subparagraph: life, accident and health annual statements; health annual statements; or fraternal annual statements, and
 - (b) the valuation manual becomes effective pursuant to order adopted by the commissioner.
4. The valuation manual must specify all of the following:
- (a) minimum valuation standards for and definitions of the policies or contracts subject to paragraph 2 of subsection B of this section. Such minimum valuation standards shall be:
 - (1) the commissioner's reserve valuation method for life insurance contracts, other than annuity contracts, subject to paragraph 2 of subsection B of this section,
 - (2) the commissioner's annuity reserve valuation method for annuity contracts subject to paragraph 2 of subsection B of this section, and
 - (3) minimum reserves for all other policies or contracts subject to paragraph 2 of subsection B of this section,
 - (b) which policies or contracts or types of policies or contracts that are subject to the requirements of a principle-based valuation in paragraph 1 of subsection Q of this section and the minimum valuation standards consistent with those requirements,
 - (c) for policies and contracts subject to a principle-based valuation under subsection Q of this section:
 - (1) requirements for the format of reports to the commissioner under subparagraph (c) of paragraph 2 of subsection Q of this section and which shall include information necessary to determine if the valuation is appropriate and in compliance with this section,
 - (2) assumptions shall be prescribed for risks over which the company does not have significant control or influence, and
 - (3) procedures for corporate governance and oversight of the actuarial function, and a process for

appropriate waiver or modification of such procedures,

- (d) for policies not subject to a principle-based valuation under subsection Q of this section, the minimum valuation standard shall either:
 - (1) be consistent with the minimum standard of valuation prior to the operative date of the valuation manual, or
 - (2) develop reserves that quantify the benefits and guarantees, and the funding, associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring,
- (e) other requirements, including, but not limited to, those relating to reserve methods, models for measuring risk, generation of economic scenarios, assumptions, margins, use of company experience, risk measurement, disclosure, certifications, reports, actuarial opinions and memorandums, transition rules and internal controls, and
- (f) the data and form of the data required under subsection R of this section, with whom the data must be submitted, and may specify other requirements, including data analyses and reporting of analyses.

5. In the absence of a specific valuation requirement or if a specific valuation requirement in the valuation manual is not, in the opinion of the commissioner, in compliance with this subsection, then the company shall, with respect to such requirements, comply with minimum valuation standards prescribed by the commissioner by regulation.

6. The commissioner may engage a qualified actuary, at the expense of the company, to perform an actuarial examination of the company and opine on the appropriateness of any reserve assumption or method used by the company, or to review and opine on a company's compliance with any requirement set forth in this section. The commissioner may rely upon the opinion, regarding provisions contained within this section, of a qualified actuary engaged by the commissioner of another state, district or territory of the United States. As used in this paragraph, the term "engage" includes employment and contracting.

7. The commissioner may require a company to change any assumption or method that in the opinion of the commissioner is necessary in order to comply with the requirements of the valuation manual or this section; and the company shall adjust the reserves as required by the commissioner. The commissioner may take other disciplinary action as permitted pursuant to rule.

Q. Requirements of a Principle-Based Valuation.

1. A company must establish reserves using a principle-based valuation that meets the following conditions for policies or contracts as specified in the valuation manual:

- (a) quantify the benefits and guarantees, and the funding, associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring during the lifetime of the contracts. For policies or contracts with significant tail risk, reflects conditions appropriately adverse to quantify the tail risk,
- (b) incorporate assumptions, risk analysis methods and financial models and management techniques that are consistent with, but not necessarily identical to, those utilized within the company's overall risk assessment process, while recognizing potential differences in financial reporting structures and any prescribed assumptions or methods,
- (c) incorporate assumptions that are derived in one of the following manners:
 - (1) the assumption is prescribed in the valuation manual,
 - (2) for assumptions that are not prescribed, the assumptions shall:
 - (i) be established utilizing the company's available experience, to the extent it is relevant and statistically credible, or
 - (ii) to the extent that company data is not available, relevant, or statistically credible, be established utilizing other relevant, statistically credible experience, and
- (d) provide margins for uncertainty including adverse deviation and estimation error, such that the greater the uncertainty the larger the margin and resulting reserve.

2. A company using a principle-based valuation for one or more policies or contracts subject to this subsection as specified in the valuation manual shall:

- (a) establish procedures for corporate governance and oversight of the actuarial valuation function consistent with those described in the valuation manual,
- (b) provide to the commissioner and the board of directors an annual certification of the effectiveness of the internal controls with respect to the principle-based

valuation. Such controls shall be designed to assure that all material risks inherent in the liabilities and associated assets subject to such valuation are included in the valuation, and that valuations are made in accordance with the valuation manual. The certification shall be based on the controls in place as of the end of the preceding calendar year, and

- (c) develop, and file with the commissioner upon request, a principle-based valuation report that complies with standards prescribed in the valuation manual.

3. A principle-based valuation may include a prescribed formulaic reserve component.

R. Experience Reporting for Policies In Force On or After the Operative Date of the Valuation Manual.

A company shall submit mortality, morbidity, policyholder behavior, or expense experience and other data as prescribed in the valuation manual.

S. When the actual funds of any life insurance company doing business in this state, exclusive of its capital, are not of a net cash value equal to its liabilities including the net value of its policies according to the basis and minimum standards prescribed or authorized by the laws of this state, it shall be the duty of the Insurance Commissioner to give notice to such company and its agents to discontinue issuing new policies within this state, until such time as its funds have become equal to its liabilities as aforesaid. Any officer or agent who, after such notice has been given, issues or delivers a new policy from and on behalf of such company before its funds have become equal to its liabilities, as aforesaid, shall forfeit to the state for each offense a sum not less than One Hundred Dollars (\$100.00) nor more than Five Thousand Dollars (\$5,000.00) for each occurrence.

T. Single State Exemption.

1. The Commissioner may exempt specific product forms or product lines of a domestic company that is licensed and doing business only in Oklahoma from the requirements of subsection P of this section provided:

- (a) the Commissioner has issued an exemption in writing to the company and has not subsequently revoked the exemption in writing, and
- (b) the company computes reserves using assumptions and methods used prior to the operative date of the valuation manual in addition to any requirements established by the commissioner and promulgated by regulation.

2. For any company granted an exemption under this section, subsections B and C of Section 4061 of this title and subsections C, D, E, F, G, H, J, K, L, M, N and O of this section shall be

applicable. With respect to any company applying this exemption, any reference to subsection P found in subsections B and C of Section 4061 and subsections C, D, E, F, G, H, J, K, L, M, N and O of this section shall not be applicable.

U. Conflict of law.

If any provision of law is inconsistent with the provisions of this section, this section shall prevail.

Added by Laws 1957, p. 283, § 1510, operative July 1, 1957. Amended by Laws 1961, p. 268, § 1, emerg. eff. July 5, 1961; Laws 1963, c. 25, §§ 1, 2; Laws 1974, c. 31, § 1, emerg. eff. April 11, 1974; Laws 1978, c. 55, § 1, emerg. eff. March 17, 1978; Laws 1982, c. 118, § 1, emerg. eff. April 6, 1982; Laws 1984, c. 149, § 5, eff. Nov. 1, 1984; Laws 2014, c. 50, § 1, eff. Nov. 1, 2014; Laws 2016, c. 73, § 4, eff. Nov. 1, 2016.

§36-1511. Valuation of bonds.

A. All bonds or other evidences of debt having a fixed term and rate of interest held by any insurer may, if amply secured and not in default as to principal or interest, be valued as follows:

1. If purchased at par, at the par value.

2. If purchased above or below par, on the basis of the purchase price adjusted so as to bring the value to par at maturity and so as to yield in the meantime the effective rate of interest at which the purchase was made, or in lieu of such method, according to such accepted method of valuation as is approved by the Insurance Commissioner.

3. Purchase price shall in no case be taken at a higher figure than the actual market value at the time of purchase, plus actual brokerage, transfer, postage or express charges paid in the acquisition of such securities.

4. Unless otherwise provided by valuation established or approved by the National Association of Insurance Commissioners, no such security shall be carried at above the call price for the entire issue during any period within which the security may be so called.

B. The Insurance Commissioner shall have full discretion in determining the method of calculating values according to the rules set forth in this section and not inconsistent with any such methods then currently formulated or approved by the National Association of Insurance Commissioners.

Laws 1957, p. 285, § 1511.

§36-1512. Valuation of other securities.

A. Securities, other than those referred to in Section 1511 of this article, held by an insurer shall be valued, in the discretion of the Insurance Commissioner, at their market value, or at true book value, all consistent with any current method for the valuation

of any such security formulated or approved by the National Association of insurance Commissioners.

B. Preferred or guaranteed stocks or shares while paying full dividends may be carried at a fixed value in lieu of market value, at the discretion of the Insurance Commissioner and in accordance with such method of computation as he may approve.

Laws 1957, p. 285, § 1512; Laws 1967, c. 242, § 1, emerg. eff. May 5, 1967.

§36-1513. Valuation of real property - Improvements.

A. Real property acquired pursuant to a mortgage loan or contract for sale shall not be valued at an amount greater than the unpaid principal of the defaulted loan or contract at the date of such acquisition, together with any taxes and expenses paid or incurred in connection with such acquisition. In addition, the company may make improvements to such property, provided however, the cost of such improvements plus the acquisition costs and unpaid principal of the defaulted loan or contract shall not exceed the lesser of four percent (4%) of the admitted assets or surplus of the company in regard to policyholders.

B. Other real property held by an insurer shall be valued at an amount not to exceed the lower of current market value or cost plus capitalized improvements less normal depreciation. In lieu of writing down investment real estate or taking part of the value as nonadmitted when market value is less than book value, an insurer may establish a reserve for specific properties as a liability. If valuation is based on an appraisal more than three (3) years old, the Insurance Commissioner may at his discretion call for and require a new appraisal in order to determine fair value.

Real property held by an insurer prior to September 1, 1993, shall be in compliance with the limitations of this section by December 31, 1997. Insurers shall maintain accurate and adequate records reflecting the provisions of this section and submit such records with quarterly and annual statements.

Added by Laws 1957, p. 285, § 1513. Amended by Laws 1989, c. 181, § 3, eff. Nov. 1, 1989; Laws 1993, c. 79, § 5, eff. Sept. 1, 1993.

§36-1514. Valuation of purchase money mortgages.

Purchase money mortgages on real property referred to in subsection A of Section 1513 of this article shall be valued in an amount not exceeding the acquisition cost of the real property covered thereby or ninety percent (90%) of the fair value of such real property, whichever is less.

Laws 1957, p. 285, § 1514.

§36-1515. Information for valuation of securities.

It shall be the duty of every domestic insurance company holding securities valued under Sections 1511 or 1512 which do not have an established market value to furnish the Commissioner of Insurance, within thirty (30) days of his request, sufficient financial information concerning the issuing corporation, so as to enable him to arrive at a proper value of the security so held. Failure to furnish such information as specified herein shall result in the security being ineligible as a deduction from liabilities.
Laws 1967, c. 242, § 6, emerg. eff. May 5, 1967.

§36-1521. Short title.

This act shall be known and may be cited as the "Risk-based Capital for Insurers Act".

Added by Laws 1997, c. 229, § 2, eff. July 1, 1997.

§36-1522. Definitions.

As used in this act:

1. "Adjusted RBC Report" means an RBC report which has been adjusted by the Insurance Commissioner in accordance with subsection D of Section 1523 of this title;
2. "Corrective order" means an order issued by the Commissioner specifying corrective actions which the Commissioner has determined are required;
3. "Domestic insurer" means any insurance company domiciled in this state;
4. "Foreign insurer" means any insurance company which has a certificate of authority to do business in this state but is not domiciled in this state;
5. "Life or health insurer" means any insurance company with a certificate of authority to write life or health insurance, or a licensed property and casualty insurer writing only accident and health insurance;
6. "Negative trend" means, with respect to a life or health insurer or a fraternal benefit society, negative trend over a period of time, as determined in accordance with the "Trend Test Calculation" included in the Life or Fraternal RBC Instructions;
7. "NAIC" means the National Association of Insurance Commissioners;
8. "Property and casualty insurer" means any insurance company with a certificate of authority to write property or casualty insurance, and shall not include monoline mortgage guaranty insurers, financial guaranty insurers, or title insurers;
9. "RBC" means risk-based capital;
10. "RBC Instructions" means the RBC Report including risk-based capital instructions adopted by the NAIC, as adopted by the Commissioner by rule, and any amendments thereto adopted by the Commissioner by rule;

11. "RBC Level" means an insurer's Company Action Level RBC, Regulatory Action Level RBC, Authorized Control Level RBC, or Mandatory Control Level RBC, where:

- a. "Company Action Level RBC" means, with respect to any insurer, the product of 2.0 and its Authorized Control Level RBC,
- b. "Regulatory Action Level RBC" means the product of 1.5 and its Authorized Control Level RBC,
- c. "Authorized Control Level RBC" means the number determined under the risk-based capital formula in accordance with RBC Instructions, and
- d. "Mandatory Control Level RBC" means the product of 0.70 and the Authorized Control Level RBC;

12. "RBC Plan" means a comprehensive financial plan containing the elements specified in subsection B of Section 1524 of this title;

13. "Revised RBC Plan" means an RBC Plan which is rejected by the Commissioner and which is revised by the insurer with or without the Commissioner's recommendations;

14. "RBC Report" means the report required in Section 1523 of this title; and

15. "Total adjusted capital" means the sum of:

- a. an insurer's statutory capital and surplus as determined in accordance with the statutory accounting applicable to the annual financial statements required to be filed with the Commissioner, and
- b. such other items, if any, as the RBC Instructions, as adopted by rule by the Commissioner, may provide.

Added by Laws 1997, c. 229, § 3, eff. July 1, 1997. Amended by Laws 2013, c. 269, § 4, eff. Nov. 1, 2013.

§36-1523. Annual risk-based capital report - Factors - Adjustment of inaccurate reports.

A. Every domestic insurer shall, on or prior to each March 1, which shall be known as the filing date, prepare and submit to the Insurance Commissioner a report of its RBC Levels as of the end of the calendar year just ended, in a form and containing such information as is required by the RBC Instructions, as adopted by the Commissioner by rule. In addition, every domestic insurer shall file its RBC Report with the NAIC if required by the Commissioner.

B. 1. A life and health insurer's or fraternal benefit society's RBC shall be determined in accordance with the formula set forth in the RBC Instructions, as adopted by the Commissioner by rule. The formula shall take into account, and may adjust for the covariance between, the following factors:

- a. the risk with respect to the insurer's assets,

- b. the risk of adverse insurance experience with respect to the insurer's liabilities and obligations,
- c. the interest rate risk with respect to the insurer's business, and
- d. all other business risks and such other relevant risks as are set forth in the RBC Instructions.

2. These factors shall be determined in each case by applying the factors in the manner set forth in the RBC Instructions.

C. 1. A property and casualty insurer's RBC shall be determined in accordance with the formula set forth in the RBC Instructions, as adopted by the Commissioner by rule. The formula shall take into account, and may adjust for the covariance between, the following factors:

- a. asset risk,
- b. credit risk,
- c. underwriting risk, and
- d. all other business risks and such other relevant risks as are set forth in the RBC Instructions.

2. These factors shall be determined in each case by applying the factors in the manner set forth in the RBC Instructions.

D. If a domestic insurer files an RBC Report which in the judgment of the Commissioner is inaccurate, then the Commissioner, after notice and opportunity for comment, shall adjust the RBC Report to correct the inaccuracy and shall notify the insurer of the adjustment. The notice shall contain a statement of the reason for the adjustment. An RBC Report so adjusted shall be referred to as an "Adjusted RBC Report".

Added by Laws 1997, c. 229, § 5, eff. July 1, 1997. Amended by Laws 2013, c. 269, § 5, eff. Nov. 1, 2013.

§36-1524. Company Action Level Event.

A. "Company Action Level Event" means any of the following events:

1. The filing of an RBC Report by an insurer which indicates that:

- a. the insurer's Total Adjusted Capital is greater than or equal to its Regulatory Action Level RBC but less than its Company Action Level RBC,
- b. if a life or health insurer, the insurer or fraternal benefit society has Total Adjusted Capital which is greater than or equal to its Company Action Level RBC but less than the product of its Authorized Control Level RBC and 3.0 and has a negative trend, or
- c. if a property and casualty insurer, the insurer has total adjusted capital which is greater than or equal to its Company Action Level RBC but less than the product of its Authorized Control Level RBC and 3.0

and triggers the trend test determined in accordance with the trend test calculation included in the Property and Casualty RBC instructions;

2. The notification by the Insurance Commissioner to the insurer of an Adjusted RBC Report that indicates an event described in paragraph 1 of this subsection, provided the insurer does not challenge the Adjusted RBC Report under Section 1528 of this title; or

3. If, pursuant to Section 1528 of this title, an insurer challenges an Adjusted RBC Report that indicates the event described in paragraph 1 of this subsection, the notification by the Commissioner to the insurer that the Commissioner has, after opportunity for a hearing, rejected the insurer's challenge.

B. In the event of a Company Action Level Event, the insurer shall, unless otherwise directed by the Commissioner, prepare and submit to the Commissioner an RBC Plan which shall include the following five elements:

1. Conditions which contribute to the Company Action Level Event;

2. Proposals of corrective actions which the insurer intends to take and which would be expected to result in the elimination of the Company Action Level Event;

3. Projections of the insurer's financial results in the current year and at least the four (4) succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, and capital and surplus. Unless the Commissioner otherwise directs, the projections for both new and renewal business shall include separate projections for each major line of business and separately identify each significant income, expense and benefit component;

4. The key assumptions impacting the insurer's projections and the sensitivity of the projections to the assumptions; and

5. The quality of, and problems associated with, the insurer's business, including, but not limited to, its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business, and use of reinsurance, if any, in each case.

C. The RBC Plan shall be submitted:

1. Within forty-five (45) days of the Company Action Level Event; or

2. If the insurer challenges an Adjusted RBC Report pursuant to Section 1528 of this title, within forty-five (45) days after notification to the insurer that the Commissioner has, after opportunity for a hearing, rejected the insurer's challenge.

D. Within sixty (60) days after the submission by an insurer of an RBC Plan to the Commissioner, the Commissioner shall notify the

insurer whether the RBC Plan shall be implemented or is, in the judgment of the Commissioner, unsatisfactory. If the Commissioner determines the RBC Plan is unsatisfactory, the notification to the insurer shall set forth the reasons for the determination, and may set forth proposed revisions which will render the RBC Plan satisfactory, in the judgment of the Commissioner. Upon notification from the Commissioner, the insurer shall prepare a Revised RBC Plan, which may incorporate by reference any revisions proposed by the Commissioner, and shall submit the Revised RBC Plan to the Commissioner:

1. Within forty-five (45) days after the notification from the Commissioner; or

2. If the insurer challenges the notification from the Commissioner under Section 1528 of this title, within forty-five (45) days after a notification to the insurer that the Commissioner has, after opportunity for a hearing, rejected the insurer's challenge.

E. In the event of a notification by the Commissioner to an insurer that the insurer's RBC Plan or Revised RBC Plan is unsatisfactory, the Commissioner may at the Commissioner's discretion, subject to the insurer's right to a hearing under Section 1528 of this title, specify in the notification that the notification constitutes a Regulatory Action Level Event.

F. Every domestic insurer that files an RBC Plan or Revised RBC Plan with the Commissioner shall file a copy of the RBC Plan or Revised RBC Plan with the insurance commissioner in any state in which the insurer is authorized to do business if:

1. The state has an RBC provision substantially similar to subsection A of Section 1531 of this title; and

2. The insurance commissioner of that state has notified the insurer of its request for the filing in writing. If such a request is made, the insurer shall file a copy of the RBC Plan or Revised RBC Plan in that state no later than the later of:

a. fifteen (15) days after the receipt of the request to file a copy of its RBC Plan or Revised RBC Plan with the state, or

b. the date on which the RBC Plan or Revised RBC Plan is filed under subsections C and D of this section.

Added by Laws 1997, c. 229, § 5, eff. July 1, 1997. Amended by Laws 2011, c. 278, § 26, eff. Nov. 1, 2011; Laws 2013, c. 269, § 6, eff. Nov. 1, 2013; Laws 2015, c. 298, § 9, eff. Nov. 1, 2015.

§36-1525. Regulatory Action Level Event.

A. "Regulatory Action Level Event" means, with respect to any insurer, any of the following events:

1. The filing of an RBC Report by the insurer which indicates that the insurer's Total Adjusted Capital is greater than or equal

to its Authorized Control Level RBC but less than its Regulatory Action Level RBC;

2. The notification by the Insurance Commissioner to an insurer of an Adjusted RBC Report that indicates the event described in paragraph 1 of this subsection, provided the insurer does not challenge the Adjusted RBC Report under Section 9 of this act;

3. If, pursuant to Section 9 of this act, the insurer challenges an Adjusted RBC Report that indicates the event described in paragraph 1 of this subsection, the notification by the Commissioner to the insurer that the Commissioner has, after opportunity for a hearing, rejected the insurer's challenge;

4. The failure of the insurer to file an RBC Report by the filing date, unless the insurer has provided an explanation for such failure in writing prior to the filing date which is satisfactory to the Commissioner, and has cured the failure within such time as may be allowed by the Commissioner;

5. The failure of the insurer to submit an RBC Plan to the Commissioner within the time period set forth in subsection C of Section 5 of this act;

6. Notification by the Commissioner to the insurer that:

- a. the RBC Plan or Revised RBC Plan submitted by the insurer is, in the judgment of the Commissioner, unsatisfactory, and
- b. such notification constitutes a Regulatory Action Level Event with respect to the insurer, provided the insurer has not challenged the determination under Section 9 of this act;

7. If, pursuant to Section 9 of this act, the insurer challenges a determination by the Commissioner under paragraph 6 of this subsection, the notification by the Commissioner to the insurer that the Commissioner has, after opportunity for a hearing, rejected such challenge;

8. Notification by the Commissioner to the insurer that the insurer has failed to adhere to its RBC Plan or Revised RBC Plan, but only if the failure has a substantial adverse effect on the ability of the insurer to eliminate the Company Action Level Event in accordance with the RBC Plan or Revised RBC Plan and the Commissioner has so stated in the notification, provided the insurer has not challenged the determination under Section 9 of this act; or

9. If, pursuant to Section 9 of this act, the insurer challenges a determination by the Commissioner under paragraph 8 of this subsection, the notification by the Commissioner to the insurer that the Commissioner has, after opportunity for a hearing, rejected the challenge.

B. In the event of a Regulatory Action Level Event:

1. The insurer shall, unless otherwise directed by the Commissioner, prepare and submit an RBC Plan or, if applicable, a Revised RBC Plan;

2. The Commissioner may perform such examination or analysis as the Commissioner deems necessary of the assets, liabilities, and operations of the insurer including a review of its RBC Plan or Revised RBC Plan; and

3. Subsequent to the examination or analysis, the Commissioner may issue a corrective order specifying the corrective actions which the Commissioner determines are required.

C. In determining corrective actions, the Commissioner may take into account the factors deemed relevant with respect to the insurer based upon the Commissioner's examination or analysis of the assets, liabilities, and operations of the insurer, including, but not limited to, the results of any sensitivity tests undertaken pursuant to the RBC Instructions. The RBC Plan or Revised RBC Plan shall be submitted:

1. Within forty-five (45) days after the occurrence of the Regulatory Action Level Event;

2. If the insurer challenges an Adjusted RBC Report pursuant to Section 9 of this act, within forty-five (45) days after the notification to the insurer that the Commissioner has, after opportunity for a hearing, rejected the insurer's challenge; or

3. If the insurer challenges a Revised RBC Plan pursuant to Section 9 of this act, within forty-five (45) days after the notification to the insurer that the Commissioner has, after opportunity for a hearing, rejected the insurer's challenge.

D. The Commissioner may retain actuaries and investment experts and other consultants as may be necessary in the judgment of the Commissioner to review the insurer's RBC Plan or Revised RBC Plan, examine or analyze the assets, liabilities, and operations of the insurer, and formulate a corrective order with respect to the insurer. The fees, costs, and expenses relating to consultants shall be borne by the affected insurer or such other party as directed by the Commissioner.

Added by Laws 1997, c. 229, § 6, eff. July 1, 1997.

§36-1526. Authorized Control Level Event.

A. "Authorized Control Level Event" means any of the following events:

1. The filing of an RBC Report by the insurer which indicates that the insurer's Total Adjusted Capital is greater than or equal to its Mandatory Control Level RBC but less than its Authorized Control Level RBC;

2. The notification by the Insurance Commissioner to the insurer of an Adjusted RBC Report that indicates the event in

paragraph 1 of this subsection, provided the insurer does not challenge the Adjusted RBC Report under Section 9 of this act;

3. If, pursuant to Section 9 of this act, the insurer challenges an Adjusted RBC Report that indicates the event in paragraph 1 of this subsection, notification by the Commissioner to the insurer that the Commissioner has, after opportunity for a hearing, rejected the insurer's challenge;

4. The failure of the insurer to respond, in a manner satisfactory to the Commissioner, to a corrective order, provided the insurer has not challenged the corrective order under Section 9 of this act; or

5. If the insurer has challenged a corrective order under Section 9 of this act and the Commissioner has, after opportunity for a hearing, rejected the challenge or modified the corrective order, the failure of the insurer to respond, in a manner satisfactory to the Commissioner, to the corrective order subsequent to rejection or modification by the Commissioner.

B. In the event of an Authorized Control Level Event with respect to an insurer, the Commissioner may:

1. Take such actions as are required under Section 6 of this act regarding an insurer with respect to which a Regulatory Action Level Event has occurred; or

2. If the Commissioner deems it to be in the best interests of the policyholders and creditors of the insurer and of the public, take such actions as are necessary to cause the insurer to be placed under regulatory control under Article 18 or 19 of the Insurance Code. In the event the Commissioner takes such actions, the Authorized Control Level Event shall be deemed sufficient grounds for the Commissioner to take action under Article 18 or 19 of the Insurance Code, and the Commissioner shall have the rights, powers, and duties with respect to the insurer as are set forth in Article 18 or 19 of the Insurance Code. In the event the Commissioner takes actions under this paragraph pursuant to an Adjusted RBC Report, the insurer shall be entitled to notice and opportunity for a hearing as required by the provisions of Article 18 or 19 of the Insurance Code.

Added by Laws 1997, c. 229, § 7, eff. July 1, 1997.

§36-1527. Mandatory Control Level Event.

A. "Mandatory Control Level Event" means any of the following events:

1. The filing of an RBC Report which indicates that the insurer's Total Adjusted Capital is less than its Mandatory Control Level RBC;

2. Notification by the Commissioner to the insurer of an Adjusted RBC Report that indicates the event in paragraph 1 of this

subsection, provided the insurer does not challenge the Adjusted RBC Report under Section 1528 of this title; or

3. If, pursuant to Section 1528 of this title, the insurer challenges an Adjusted RBC Report that indicates the event in paragraph 1 of this subsection, notification by the Commissioner to the insurer that the Commissioner has, after opportunity for a hearing, rejected the insurer's challenge.

B. In the event of a Mandatory Control Level Event:

1. With respect to a life insurer or fraternal benefit society, the Commissioner may take the actions necessary to place the insurer under regulatory control under Article 18 or 19 of the Insurance Code. In that event, the Mandatory Control Level Event is deemed sufficient grounds for the Commissioner to take action under Article 18 or 19 of the Insurance Code, and the Commissioner shall have the rights, powers, and duties with respect to the insurer which are set forth in Article 18 or 19 of the Insurance Code. If the Commissioner takes actions pursuant to an Adjusted RBC Report, the insurer shall be entitled to notice and opportunity for a hearing as required by the provisions of Article 18 or 19 of the Insurance Code; and

2. With respect to a property and casualty insurer, the Commissioner may take the actions necessary to place the insurer under regulatory control under Article 18 or 19 of the Insurance Code, or, in case of an insurer which is writing no business and which is running-off its existing business, may allow the insurer to continue its run-off under the supervision of the Commissioner. In either event, the Mandatory Control Level Event is deemed sufficient grounds for the Commissioner to take action under Article 18 or 19 of the Insurance Code and the Commissioner shall have the rights, powers, and duties with respect to the insurer which are set forth in Article 18 or 19 of the Insurance Code. If the Commissioner takes actions pursuant to an Adjusted RBC Report, the insurer shall be entitled to notice and opportunity for a hearing as required by the provisions of Article 18 or 19 of the Insurance Code.

Added by Laws 1997, c. 229, § 8, eff. July 1, 1997. Amended by Laws 2013, c. 269, § 7, eff. Nov. 1, 2013.

§36-1528. Confidential departmental hearing.

The insurer shall have the right to an opportunity for a confidential departmental hearing, on the record, at which the insurer may challenge any determination or action by the Commissioner. The insurer shall notify the Commissioner of its request for a hearing within five (5) days after the notification by the Commissioner of a decision affecting the insurer's substantial rights. Upon receipt of the insurer's request for a hearing, the Commissioner shall set a date for the hearing, which date shall be no less than five (5) days after the date of the insurer's request.

The Commissioner may deny a request for hearing if the request is frivolous, or if no factual issues are presented.

Added by Laws 1997, c. 229, § 9, eff. July 1, 1997.

§36-1529. Confidentiality of RBC Reports and Plans.

A. RBC Reports and RBC Plans shall be kept confidential by the Insurance Commissioner. This information shall not be subject to subpoena. This information shall be made public by the Commissioner only for the purpose of enforcement actions taken by the Commissioner pursuant to this act or any other provision of the insurance laws of this state.

B. Except as otherwise required under the provisions of this act, the making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing an assertion, representation, or statement with regard to the RBC Levels of any insurer, or of any component derived in the calculation, by an insurer, agent, broker, or other person engaged in any manner in the insurance business is misleading and is therefore prohibited. Any person who violates this subsection shall be subject to a civil penalty in an amount not less than One Thousand Dollars (\$1,000.00) nor more than Ten Thousand Dollars (\$10,000.00).

C. The RBC Reports and RBC Plans are intended solely for use by the Commissioner in monitoring the solvency of insurers and the need for possible corrective action with respect to insurers. The RBC Reports and RBC Plans shall not be used by the Commissioner for ratemaking nor considered or introduced as evidence in any rate proceeding nor used by the Commissioner to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance which an insurer or any affiliate is authorized to write.

Added by Laws 1997, c. 229, § 10, eff. July 1, 1997.

§36-1530. Provisions of act supplemental - Promulgation of rules - Exemptions from act.

A. The provisions of this act are supplemental to any other provisions of the laws of this state, and shall not preclude or limit any other powers or duties of the Insurance Commissioner under such laws, including, but not limited to, Article 18 or 19 of the Insurance Code.

B. The Commissioner may promulgate reasonable rules necessary for the implementation of this act.

C. The Commissioner may exempt from the application of this act in any year any domestic insurer which:

1. Writes direct business only in this state; and
2. Assumes no reinsurance in excess of five percent (5%) of direct premium written.

D. Insurers domiciled in this state that are issuing policies of medical professional liability insurance to physicians, allied health care professionals and health care institutions as defined by Section 2202 of this title on July 1, 2004, which notify the Commissioner in writing of the insurer's election to utilize the moratorium provided in Section 1509 of this title shall be exempt from the provisions of this title which require an insurer to maintain an adequate surplus as regards policyholders as a condition to obtaining or renewal of a license to act as an insurer, until December 31, 2008. The Commissioner shall not enforce any recapitalization plan against any insurer domiciled in this state that is issuing policies of physicians', allied health care professionals' and health care institutions' professional liability insurance until December 31, 2008.

Added by Laws 1997, c. 229, § 11, eff. July 1, 1997. Amended by Laws 2004, c. 368, § 57, eff. July 1, 2004; Laws 2005, c. 44, § 2, eff. Nov. 1, 2005.

§36-1531. Foreign insurers.

A. 1. Any foreign insurer shall, upon the written request of the Insurance Commissioner, submit to the Commissioner an RBC Report as of the end of the calendar year just ended on a date which is the later of:

- a. the date an RBC Report would be required to be filed by a domestic insurer under this act, or
- b. fifteen (15) days after the request is received by the foreign insurer.

2. Any foreign insurer shall, at the written request of the Commissioner, promptly submit to the Commissioner a copy of any RBC Plan that is filed with the Insurance Commissioner of any other state.

B. 1. The Commissioner may require a foreign insurer to file an RBC Plan with the Commissioner in the event of a Company Action Level Event, Regulatory Action Level Event, or Authorized Control Level Event. The filing shall be made pursuant to the RBC statute applicable in the state of domicile of the insurer or, if no RBC statute is in force in that state, pursuant to the provisions of this act. If the insurance commissioner of the state of domicile of the foreign insurer fails to require the foreign insurer to file an RBC Plan in the manner specified under that state's RBC statute or, if no RBC statute is in force in that state, the filing shall be made pursuant to Section 5 of this act.

2. The failure of the foreign insurer to file an RBC Plan with the Commissioner shall be grounds to order the insurer to cease and desist from writing new insurance business in this state.

C. In the event of a Mandatory Control Level Event with respect to any foreign insurer, if no domiciliary receiver has been appointed with respect to the foreign insurer under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign insurer, the Commissioner may make application to the Oklahoma County District Court as permitted under Article 19 of the Oklahoma Insurance Code with respect to the liquidation of property of foreign insurers found in this state. Added by Laws 1997, c. 229, § 12, eff. July 1, 1997.

§36-1532. Immunity for Commissioner and employees.

There shall be no liability on the part of, and no cause of action shall arise against, the Insurance Commissioner or the Insurance Department or its employees or agents for any action taken by them in the performance of their powers and duties under this act.

Added by Laws 1997, c. 229, § 13, eff. July 1, 1997.

§36-1533. Notices to insurers - When effective.

All notices by the Insurance Commissioner to an insurer which may result in regulatory action hereunder shall be effective upon dispatch if transmitted by registered or certified mail, or in the case of any other transmission shall be effective upon the insurer's receipt of such notice.

Added by Laws 1997, c. 229, § 14, eff. July 1, 1997.

§36-1534. Purpose of act.

A. The purpose of this act is to:

1. Provide the Commissioner of the Oklahoma Insurance Department a summary of an insurer or insurance group's corporate governance structure, policies and practices to permit the Commissioner to gain and maintain an understanding of the insurer's corporate governance framework;

2. Outline the requirements for completing a Corporate Governance Annual Disclosure (CGAD) with the Commissioner; and

3. Provide for the confidential treatment of the CGAD and related information that will contain confidential and sensitive information related to an insurer or insurance group's internal operations and proprietary and trade secret information which, if made public, could potentially cause the insurer or insurance group competitive harm or disadvantage.

B. Nothing in this act shall be construed to prescribe or impose corporate governance standards and internal procedures beyond those which are required under applicable state corporate law.

Notwithstanding the foregoing, nothing in this act shall be construed to limit the Commissioner's authority or the rights or obligations of third parties under Sections 309.1 through 309.7 of Title 36 of the Oklahoma Statutes.

C. The requirements of this act shall apply to all insurers domiciled in this state.

Added by Laws 2019, c. 345, § 1, eff. Nov. 1, 2019.

§36-1535. Definitions.

As used in this act:

1. "Commissioner" means the Insurance Commissioner of this state;

2. "Corporate Governance Annual Disclosure (CGAD)" means a confidential report filed by the insurer or insurance group made in accordance with the requirements of this act;

3. "Insurance group" means those insurers and affiliates included within an insurance holding company system as defined in Section 1631 of Title 36 of the Oklahoma Statutes;

4. "Insurer" means the same as set forth in Section 103 of Title 36 of the Oklahoma Statutes, except that it shall not include agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state; and

5. "ORSA Summary Report" means the report filed in accordance with Section 3305 of Title 36 of the Oklahoma Statutes.

Added by Laws 2019, c. 345, § 2, eff. Nov. 1, 2019.

§36-1536. Corporate Governance Annual Disclosure (CGAD).

A. An insurer or the insurance group of which the insurer is a member shall, no later than June 1 of each calendar year, submit to the Insurance Commissioner a Corporate Governance Annual Disclosure (CGAD) that contains the information described in Section 4 of this act. Notwithstanding any request from the Commissioner made pursuant to subsection C of this section, if the insurer is a member of an insurance group, the insurer shall submit the report required by this section to a commissioner of the lead state for the insurance group, in accordance with the laws of the lead state, as determined by the procedures outlined in the most recent Financial Analysis Handbook adopted by the National Association of Insurance Commissioners (NAIC).

B. The CGAD shall include a signature of the insurer or chief executive officer or corporate secretary of the insurance group attesting to the best of his or her belief and knowledge that the insurer has implemented the corporate governance practices and that a copy of the disclosure has been provided to the insurer's board of directors or the appropriate committee thereof.

C. An insurer not required to submit a CGAD under this section shall do so upon the Commissioner's request.

D. For purposes of completing the CGAD, the insurer or insurance group may provide information regarding corporate governance at the ultimate controlling parent level, an intermediate holding company level and/or the individual legal entity level, depending upon how the insurer or insurance group has structured its system of corporate governance. The insurer or insurance group is encouraged to make the CGAD disclosures at the level at which the insurer's or insurance group's risk appetite is determined, or at which the earnings, capital, liquidity, operations and reputation of the insurer are overseen collectively and at which the supervision of those factors is coordinated and exercised, or the level at which legal liability for failure of general corporate governance duties would be placed. If the insurer or insurance group determines the level of reporting based on these criteria, it shall indicate which of the three criteria was used to determine the level of reporting and explain any subsequent changes in level of reporting.

E. The review of the CGAD and any additional requests for information shall be made through the lead state as determined by the procedures within the most recent Financial Analysis Handbook referenced in subsection A of this section.

F. Insurers providing information substantially similar to the information required by this act in other documents provided to the Commissioner, including proxy statements filed in conjunction with Form B requirements, or other state or federal filings provided to the Oklahoma Insurance Department shall not be required to duplicate that information in the CGAD but shall only be required to cross-reference the document in which the information is included.

Added by Laws 2019, c. 345, § 3, eff. Nov. 1, 2019.

§36-1537. Discretion of insurer or insurance group over responses.

A. The insurer or insurance group shall have discretion over the responses to the Corporate Governance Annual Disclosure (CGAD) inquiries, provided the CGAD shall contain the material information necessary to permit the Insurance Commissioner to gain an understanding of the insurer's or group's corporate governance structure, policies, and practices. The Commissioner may request additional information that he or she deems material and necessary to provide a clear understanding of the corporate governance policies, the reporting or information system or controls implementing those policies.

B. Notwithstanding subsection A of this section, the CGAD shall be prepared consistent with any regulation created to support this act. Documentation and supporting information shall be maintained and made available upon examination or upon request of the Commissioner.

Added by Laws 2019, c. 345, § 4, eff. Nov. 1, 2019.

§36-1538. Confidentiality and privilege.

A. Documents, materials or other information including the Corporate Governance Annual Disclosure (CGAD), in the possession or control of the Oklahoma Insurance Department that is obtained by, created by or disclosed to the Insurance Commissioner or any other person under this act, is recognized by this state as being proprietary and to contain trade secrets. All such documents, materials or other information shall be confidential by law and privileged, shall not be subject to the Oklahoma Open Records Act, subpoena, and discovery or admissible in evidence in any private civil action. However, the Commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the Commissioner's official duties. The Commissioner shall not otherwise make the documents, materials or other information public without the prior written consent of the insurer. Nothing in this section shall be construed to require written consent of the insurer before the Commissioner may share or receive confidential documents, materials or other CGAD-related information pursuant to subsection C of this section to assist in the performance of the Commissioner's regular duties.

B. Neither the Commissioner nor any person who received documents, materials or other CGAD-related information, through examination or otherwise, while acting under the authority of the Commissioner, or with whom such documents, materials or other information is shared pursuant to this act shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subsection A of this section.

C. In order to assist in the performance of the Commissioner's regulatory duties, the Commissioner:

1. May, upon request, share documents, materials or other CGAD-related information including the confidential and privileged documents, materials or information subject to subsection A of this section, including proprietary and trade secret documents and materials, with other state, federal and international financial regulatory agencies, including members from the National Association of Insurance Commissioners (NAIC), and with third-party consultants pursuant to Section 6 of this act, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the CGAD-related documents, material or other information and has verified in writing the legal authority to maintain confidentiality; and

2. May receive documents, materials or other CGAD-related information, including otherwise confidential and privileged

documents, materials or information, including proprietary and trade secret information or documents, from regulatory officials of other state, federal and international financial regulatory agencies, including members from the NAIC and shall maintain as confidential or privileged any documents, materials or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the documents, materials or information.

D. The sharing of information and documents by the Commissioner pursuant to this act shall not constitute a delegation of regulatory authority or rulemaking, and the Commissioner is solely responsible for the administration, execution and enforcement of the provisions of this act.

E. No waiver of any applicable privilege or claim of confidentiality in the documents, proprietary and trade secret materials or other CGAD-related information shall occur as a result of disclosure of such CGAD-related information or documents to the Commissioner under this section or as a result of sharing as authorized in this act.

Added by Laws 2019, c. 345, § 5, eff. Nov. 1, 2019.

§36-1539. Third-party consultants to assist the Commissioner in reviewing documents.

A. The Insurance Commissioner may retain, at the insurer's expense, third-party consultants, including attorneys, actuaries, accountants and other experts not otherwise a part of the Commissioner's staff as may be reasonably necessary to assist the Commissioner in reviewing the Corporate Governance Annual Disclosure (CGAD) and related information or the insurer's compliance with this act.

B. Any persons retained under subsection A of this section shall be under the direction and control of the Commissioner and shall act in a purely advisory capacity.

C. The National Association of Insurance Commissioners (NAIC) and third-party consultants shall be subject to the same confidentiality standards and requirements as the Commissioner.

D. As part of the retention process, a third-party consultant shall verify to the Commissioner, with notice to the insurer, that it is free of a conflict of interest and that it has internal procedures in place to monitor compliance with a conflict and to comply with the confidentiality standards and requirements of this act.

E. A written agreement with the NAIC and/or a third-party consultant governing sharing and use of information provided pursuant to this act shall contain the following provisions and expressly require the written consent of the insurer prior to making public information provided under this act:

1. Specific procedures and protocols for maintaining the confidentiality and security of CGAD-related information shared with the NAIC or a third-party consultant pursuant to this act;

2. Procedures and protocols for sharing by the NAIC only with other state regulators from states in which the insurance group has domiciled insurers. The agreement shall provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the CGAD-related documents, materials or other information and has verified in writing the legal authority to maintain confidentiality;

3. A provision specifying that ownership of the CGAD-related information shared with the NAIC or a third-party consultant remains with the Department of Insurance and the NAIC's or third-party consultant's use of the information is subject to the direction of the Commissioner;

4. A provision that prohibits the NAIC or a third-party consultant from storing the information shared pursuant to this act in a permanent database after the underlying analysis is completed;

5. A provision requiring the NAIC or third-party consultant to provide prompt notice to the Commissioner and to the insurer or insurance group regarding any subpoena, request for disclosure, or request for production of the insurer's CGAD-related information; and

6. A requirement that the NAIC or a third-party consultant consents to intervention by an insurer in any judicial or administrative action in which the NAIC or a third-party consultant may be required to disclose confidential information about the insurer shared with the NAIC or a third-party consultant pursuant to this act.

Added by Laws 2019, c. 345, § 6, eff. Nov. 1, 2019.

§36-1540. Failure to timely file.

Any insurer failing, without just cause, to timely file the Corporate Governance Annual Disclosure (CGAD) as required in this act shall be required, after notice and hearing, to pay a penalty of One Hundred Dollars (\$100.00) for each day's delay, to be recovered by the Insurance Commissioner and the penalty so recovered shall be paid into the General Revenue Fund of this state. The maximum penalty under this section is Ten Thousand Dollars (\$10,000.00). The Commissioner may reduce the penalty if the insurer demonstrates to the Commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.

Added by Laws 2019, c. 345, § 7, eff. Nov. 1, 2019.

§36-1541. Promulgation of rules.

The Insurance Commissioner may, upon notice and opportunity for all interested persons to be heard, issue such rules and orders as shall be necessary to carry out the provisions of this act.
Added by Laws 2019, c. 345, § 8, eff. Nov. 1, 2019.

§36-1601. Scope of article.

Except as to Sections 1624 and 1625 and subdivision A of Section 1606 hereof, this article applies to domestic insurers only. This article shall apply to domestic title insurers except as provided in Article 50 (Title Insurers).
Laws 1957, p. 285, § 1601.

§36-1602. Eligible investments.

A. Insurers shall invest in or loan their funds on the security of, and shall hold as assets, only eligible investments as prescribed in this article.

B. Any particular investment held by an insurer on the effective date of this Code or any amendment hereto, and which was a legal investment at the time it was made, and which the insurer was legally entitled to possess immediately prior to such effective date, shall be deemed to be an eligible investment.

C. The eligibility of an investment shall be determined as of the date of its making or acquisition.

D. Any investment limitation based upon the amount of the insurer's assets or particular funds shall relate to assets or funds as shown by the insurer's annual statement as of December 31 last preceding date of investment, or as shown by a current financial statement on file with the Commissioner.

Laws 1957, p. 285, § 1602; Laws 1965, c. 123, § 1; Laws 1967, c. 242, § 2, emerg. eff. May 5, 1967.

§36-1603. Qualification of securities or property as eligible investments.

A. No security or investment (other than property or shares acquired pursuant to Sections 1612, 1616 or 1624 of this article) shall be eligible for acquisition unless it is interest bearing or interest accruing or dividend or income paying, is not then in default in any respect, and the insurer is entitled to receive for its exclusive account and benefit the interest or income accruing thereon. Defaults in interest or income occurring subsequent to acquisition of an investment shall not affect allowance thereof as an asset.

B. No security or investment shall be eligible for purchase at a price above its market value.

C. No provision of this article shall prohibit the acquisition by an insurer of other or additional securities or property if received as a dividend or as a lawful distribution of assets, or if

acquired pursuant to a lawful and bona fide agreement of bulk reinsurance, merger, or consolidation. Any investment so acquired through bulk reinsurance, merger, or consolidation, which is not otherwise eligible under this article, shall be disposed of pursuant to Section 1625 of this article.

Laws 1957, p. 286, § 1603; Laws 1965, c. 123, § 2.

§36-1604. Approval of investment.

No investment or loan shall be made by an insurer unless the same has been authorized or approved by the insurer's board of directors or by a committee or corporate officer authorized thereby and charged with the duty of supervising or making such investment or loan. The minutes of any such committee shall be recorded and regular reports of such committee shall be submitted to the board of directors. This section does not apply to loans made by a life insurer on policies or annuity contracts.

Laws 1957, p. 286, § 1604; Laws 1965, c. 123, § 3.

§36-1605. Investments in any one person.

An insurer shall not, except with the consent of the Insurance Commissioner, have at any one time any combination of checking account moneys, investments in or loans upon the security of the obligations, property, or securities of any one person, institution, corporation, or municipal corporation, aggregating an amount exceeding ten percent (10%) of the insurer's admitted assets. This restriction shall not apply to investments in or loans upon the security of general obligations of the United States or any state of the United States or include policy loans made under Section 1619 of this title, or investments made under Section 1616 of this title.

Added by Laws 1957, p. 286, § 1605, operative July 1, 1957. Amended by Laws 1965, c. 123, § 4; Laws 1967, c. 242, § 3, emerg. eff. May 5, 1967; Laws 1984, c. 149, § 6, eff. Nov. 1, 1984; Laws 2018, c. 95, § 5, eff. Nov. 1, 2018.

§36-1606. Required capital investments.

After the effective date of this act, until an insurer authorized to transact business shall have assets of One Million Dollars (\$1,000,000.00) or in the case of insurers authorized to transact business prior to the effective date of this act shall have assets in an amount equal to three (3) times the minimum paid-in capital that was required of a like domestic stock insurer on January 1, 1979, it shall invest and maintain its funds only in cash and the securities described in the following sections of this article: Section 1607 (Securities of or guaranteed by the United States); Section 1608 (State and Canadian public obligations); Section 1609 (County, municipal and district obligations); Section

1610 (Public improvement bonds); and Section 1620 (Deposits: Banks, Savings and Loan).

Laws 1957, p. 286, § 1606; Laws 1959, p. 292, § 8; Laws 1965, c. 123, § 5; Laws 1967, c. 242, § 4, emerg. eff. May 5, 1967; Laws 1980, c. 185, § 8, eff. Oct. 1, 1980.

§36-1607. United States government obligations.

An insurer may invest any of its funds in:

1. Bonds or other evidences of indebtedness of the United States of America or of any of its agencies or instrumentalities when such obligations are guaranteed as to principal and interest by the United States of America or any agency or instrumentality thereof.

2. Bonds or other evidences of indebtedness which are guaranteed as to principal and interest by the United States of America or by any agency or instrumentality of the United States of America.

3. Bonds, debentures or other securities of the following agencies of the government of the United States, whether or not such obligations are guaranteed by such government:

(a) Commodity credit corporation.

(b) Federal national mortgage association and stock thereof when acquired in connection with sale of mortgage loans to such association.

(c) Federal land banks, issued under provisions of the Act of Congress entitled the "Federal Farm Loan Act" and approved July 17, 1916, and any acts amendatory or supplementary to that Act.

(d) Any federal home loan bank, issued under provisions of the Act of Congress entitled "Federal Home Loan Bank Act" and approved July 22, 1932.

(e) The Home Owners' Loan Corporation, created by the Act of Congress entitled "Home Owners' Loan Act of 1933" and approved June 13, 1933.

(f) Federal intermediate credit banks, created by the Act of Congress entitled "Agricultural Credits Act of March 4, 1923."

(g) Central bank for cooperatives and regional banks for cooperatives organized under the Farm Credit Act of 1933, or by any of such banks.

(h) Any other similar agency of the government of the United States and of similar financial quality.

Laws 1957, p. 287, § 1607; Laws 1965, c. 123, § 6.

§36-1608. State, district or Canadian obligations.

An insurer may invest in bonds, notes, warrants and other securities not in default which are the direct obligations of any state of the United States or of the District of Columbia, or of the government of Canada or any province thereof, or for which the full

faith and credit of such state, district, government or province has been pledged for the payment of principal and interest. Bonds, notes, warrants and other securities classified as revenue, prerefunded or declining balances are not considered acceptable investments for this purpose.

Added by Laws 1957, p. 287, § 1608, operative July 1, 1957. Amended by Laws 1965, c. 123, § 7; Laws 2012, c. 44, § 6, eff. Nov. 1, 2012.

§36-1609. County, district, city, school district or Canadian obligations.

An insurer may invest in bonds, notes, warrants and other securities not in default of any county, district, incorporated city, or school district in any state of the United States, or the District of Columbia, or in any province of Canada, which are the direct obligations of such county, district, city or school district and for payment of the principal and interest of which the county, district, city, or school district has lawful authority to levy taxes or make assessments. Bonds, notes, warrants and other securities classified as revenue, prerefunded or declining balances are not considered acceptable investments for this purpose.

Added by Laws 1957, p. 287, § 1609, operative July 1, 1957. Amended by Laws 1965, c. 123, § 8; Laws 2012, c. 44, § 7, eff. Nov. 1, 2012.

§36-1610. Public structure or improvement obligations.

An insurer may invest in bonds, notes, certificates of indebtedness, warrants, or other evidences of indebtedness, which are payable from revenues or earnings specifically pledged therefor of any public structure or improvement owned by any state, incorporated city, or legally-constituted public corporation or commission or trust, all within the United States, for the payment of the principal and interest if no default on the part of the issuer in payment of principal or interest has occurred on any of its bonds, notes, warrants, or other securities within five (5) years prior to the date of investment therein, or, if such obligations were issued less than five (5) years prior to the date of investment, no default in payment of principal or interest has occurred on the obligations to be purchased or on any other obligation of the issuer within five (5) years of such investment. Laws 1957, p. 287, § 1610; Laws 1965, c. 123, § 9.

§36-1611. Obligations payable from public utility revenues.

An insurer may invest in the bonds, notes, certificates of indebtedness, warrants, or other evidences of indebtedness which are valid obligations issued, assumed, or guaranteed by the United States or any state thereof or by any county, municipal corporation, district, or political subdivision or civil division or public instrumentality of any such government or unit thereof, if by

statute or other legal requirements such obligations are payable as to both principal and interest from revenues or earnings from the whole or any part of any utility supplying water, gas, sewage disposal facility or electricity or any other public service. Laws 1957, p. 287, § 1611; Laws 1965, c. 123, § 10.

§36-1612. Repealed by Laws 2004, c. 334, § 42, emerg. eff. May 25, 2004.

§36-1612.1. Repealed by Laws 2021, c. 478, § 42, emerg. eff. May 12, 2021.

§36-1613. Acceptances and bill of exchange.

An insurer may invest in bank and bankers' acceptances and other bills of exchange of the kind and maturity made eligible pursuant to law for purchase in the open market by federal reserve banks. Laws 1957, p. 287, § 1613.

§36-1614. Corporate obligations.

A. An insurer may invest in bonds, debentures, notes and other evidences of indebtedness issued, assumed or guaranteed by any solvent institutions created or existing under the laws of the United States or of any state, district or territory thereof, which are not in default as to principal or interest.

B. An insurer may invest in fixed interest bearing obligations, other than those described in subsection A of this section, of such institutions if not in default.

Laws 1957, p. 288, § 1614; Laws 1965, c. 123, § 12.

§36-1615. Preferred or guaranteed stock.

An insurer may invest in preferred or guaranteed stocks or shares of any solvent institution created or existing under the laws of the United States or of any state, district or territory thereof, if such stock and all of the prior obligations and prior preferred stocks, if any, of such institution at the date of acquisition by such insurer are not then in default.

Laws 1957, p. 288, § 1615; Laws 1965, c. 123, § 13.

§36-1616. Limitations on investments in corporate securities.

A. Except with the consent of the Insurance Commissioner, no domestic life insurer shall, in addition to other investments permitted by this article, invest an amount equal in the aggregate to more than ten percent (10%) of its assets, or in the case of a domestic nonlife insurer, an amount equal in the aggregate to more than twenty percent (20%) of its assets in the shares of solvent corporations created or existing under the laws of the United States or of any state. Investing in the shares of mutual funds that

invest only in bonds or preferred stocks shall be considered as investing in bonds or preferred stocks, and investing in mutual funds that invest in common stocks shall be considered as investing in common stocks. However, investments in the shares of subsidiaries or companion insurance companies shall be governed by Section 1652 of this title and this subsection shall not apply to investments by domestic insurers in the shares of insurance subsidiaries.

B. For the purpose of determining the investment limitation imposed by this article, the insurer shall value securities purchased pursuant to the provisions of this article at the cost of the security or at the market value of the security, whichever is lower.

Added by Laws 1957, p. 288, § 1616, operative July 1, 1957. Amended by Laws 1959, p. 136, § 1, emerg. eff. April 15, 1959; Laws 1965, c. 123, § 14; Laws 1967, c. 242, § 5, emerg. eff. May 5, 1967; Laws 1975, c. 14, § 1; Laws 2005, c. 129, § 12, eff. Nov. 1, 2005; Laws 2005, c. 425, § 2, eff. Nov. 1, 2005; Laws 2007, c. 125, § 17, eff. July 1, 2007.

§36-1617. Equipment trust certificates.

An insurer may invest in equipment trust obligations or certificates which in the opinion of the Insurance Commissioner are adequately secured, or other instruments so secured and evidencing an interest in transportation equipment, wholly or in part within the United States, which carry the right to receive determined portions of rental, purchase, or other fixed obligatory payments to be made for the use or purchase of such transportation equipment. Laws 1957, p. 289, § 1617.

§36-1618. Obligations of receivers or trustees; investments not otherwise authorized; limitations.

A. An insurer may invest in certificates, notes or other obligations issued by trustees or receivers of any institution created or existing under the laws of the United States or of any state, district or territory thereof, which, or the assets of which, are being administered under the direction of any court having jurisdiction, if such obligation in the opinion of the Insurance Commissioner is adequately secured as to principal and interest.

B. An insurer may make loans or investments not otherwise qualifying or permitted under this article to an amount not exceeding in the aggregate ten percent (10%) of the insurer's assets, and not exceeding one percent (1%) of such assets as to any one such loan or investment. But no such loan or investment shall be represented by:

1. Any item described in Section 1503 of this title, or any loan or investment otherwise specifically prohibited;

2. Any loan or investment eligible under any other provision of this article; or

3. Any asset theretofore acquired or held by the insurer under any other category of loans or investments eligible under this article.

The insurer shall keep a separate record of all loans and investments made under this subsection.

Added by Laws 1957, p. 289, § 1618, emerg. eff. May 27, 1957.

Amended by Laws 2022, c. 13, § 1, emerg. eff. April 19, 2022.

§36-1619. Policy loans.

A life insurer may lend to its policyholder upon pledge of the policy as collateral security a sum not exceeding the applicable cash surrender value specified in the policy.

Laws 1957, p. 289, § 1619.

§36-1620. Investment or deposit of funds.

A. An insurer may invest or deposit any of its cash funds on deposit in checking or savings accounts, under certificates of deposit, or in solvent banks or trust companies, which are insured by the Federal Deposit Insurance Corporation.

B. An insurer may invest or deposit any of its funds in checking, share or saving accounts under certificates of deposit or time deposits in solvent savings and loan associations which are insured by the Federal Deposit Insurance Corporation.

C. An insurer may invest or deposit any of its cash funds in share, share draft, under certificates of deposit or time deposits in solvent credit unions which are insured by the National Credit Union Administration.

D. All certificates of deposits or other time deposit instruments shall be classified as negotiable and transferrable as required by Section 1703 of this title.

Added by Laws 1957, p. 289, § 1620, operative July 1, 1957. Amended by Laws 1980, c. 362, § 20, emerg. eff. June 27, 1980; Laws 1986, c. 251, § 25, eff. Nov. 1, 1986; Laws 1987, c. 175, § 17, eff. Nov. 1, 1987; Laws 2012, c. 44, § 8, eff. Nov. 1, 2012.

§36-1621. Foreign securities.

Provided nothing contained herein shall prevent a domestic company doing business in other states of the United States or in foreign countries from investing the funds required to meet its obligations incurred in such other states or foreign countries in the kind of securities that such companies are required by law or permitted by law to invest in that state.

Laws 1957, p. 289, § 1621.

§36-1622. Mortgages on real estate.

A. An insurer may invest any of its funds in bonds, notes or other evidences of indebtedness which are secured by first mortgages or deeds of trust upon improved, unencumbered real property located in the United States, or which are secured by first mortgages or deeds of trust upon leasehold estates having an expired term of not less than twenty-one (21) years, inclusive of the term which may be provided by an enforceable option of renewal, in improved, unencumbered real property located in the United States.

B. Real property shall not be deemed to be encumbered within the meaning of this section by reason of the existence of instruments reserving mineral, oil or timber rights, rights-of-way, sewer rights, rights in walls, nor by reason of any liens for taxes or assessments not delinquent, nor by reason of building restrictions or other restrictive covenants, nor when such real property is subject to lease under which rents or profits are reserved to the owner, if in any event the security for such loan is a first lien upon such real property and if there is no condition or right of reentry or forfeiture under which, in the case of real property other than leaseholds, such lien can be cut off, subordinated, or otherwise disturbed or under which, in the case of leaseholds, the insurer is unable to continue the lease in force for the duration of the loan.

C. 1. No such mortgage loan or loans made or acquired by an insurer on any one property shall, at the time of investment by the insurer, exceed eighty percent (80%) of the value, or if the loan is for purchase money, the lesser of eighty percent (80%) of the value or purchase price of the real property or leasehold securing the same, except that such loan or loans may equal the amount of any guaranty by the United States of America or by any agency or instrumentality of the United States of America or by any private insurance company licensed as an authorized insurer by the Insurance Department of the State of Oklahoma to write mortgage insurance. Additionally, no single mortgage loan to any individual shall exceed three percent (3%) of the company's admitted assets, with no more than thirty-five percent (35%) of the company's admitted assets invested in total aggregate amount in mortgage loans; provided, however, that an insurer may invest up to forty-five percent (45%) of the company's admitted assets invested in total aggregate amount in mortgage loans if the portfolio average loan to value is seventy-five percent (75%) or less of fair market value. The calculation of admitted assets and portfolio average loan to value is based on the insurer's annual statement as of December 31 last preceding the date of investment, or as shown by a current financial statement on file with the Commissioner.

2. Mortgage loans made or acquired by an insurer prior to December 31, 1992, shall be in compliance with the limitation provided in this subsection for total aggregate investment of

admitted assets in mortgage loans by December 31, 1997. Mortgage loans made or acquired by an insurer on or after December 31, 1992, but prior to September 1, 1993, shall be in compliance with the limitations for investment of admitted assets in single mortgage loans to individuals and total aggregate investments of admitted assets in mortgage loans provided in this subsection by December 31, 1997. Insurers shall maintain accurate and adequate records reflecting the provisions of this section and submit such records with quarterly and annual statements.

D. No such mortgage loan or loans shall be made or acquired by an insurer except after an appraisal made by a qualified appraiser for the purpose of such investment. No change or modification shall be made to such appraisal by any mortgage underwriter unless such person is licensed or certified as an appraiser pursuant to the Oklahoma Certified Real Estate Appraisers Act or unless such person has been provided by the person who made the appraisal written consent to make the modification. Such modification shall be disclosed to the seller and buyer and/or the seller's agent.

E. No such mortgage loan or loans made or acquired by an insurer after July 1, 2006, shall be made or acquired by an insurer unless the mortgages or mortgage loans are upon improved, unencumbered real property permitted as an investment pursuant to Section 1624 of this title.

F. No mortgage loan upon a leasehold shall be made or acquired pursuant to this section unless the terms thereof shall provide for amortization payments to be made by the borrower on the principal thereof at least once in each year in amounts sufficient completely to amortize the loan within a period of four-fifths (4/5) of the term of the leasehold, inclusive of the term which may be provided by an enforceable option of renewal, which is unexpired at the time the loan is made, but in no event exceeding thirty-five (35) years.

G. Subject to specific limitations otherwise applicable, no more than an aggregate of thirty-five percent (35%), except as provided in paragraph 1 of subsection C of this section, of the company's admitted assets may be invested in mortgage loans pursuant to this section, purchase money mortgages pursuant to Section 1623 of this title, and real property pursuant to Section 1624 of this title.

Added by Laws 1957, p. 289, § 1622, operative July 1, 1957. Amended by Laws 1965, c. 123, § 15; Laws 1974, c. 83, § 1, emerg. eff. April 19, 1974; Laws 1993, c. 79, § 6, eff. Sept. 1, 1993; Laws 1993, c. 360, § 4, eff. Sept. 1, 1993; Laws 2006, c. 264, § 49, eff. July 1, 2006; Laws 2017, c. 287, § 3, eff. Nov. 1, 2017; Laws 2021, c. 274, § 1, emerg. eff. April 27, 2021.

NOTE: Laws 1993, c. 16, § 1 repealed by Laws 1993, c. 360, § 16, emerg. eff. June 10, 1993.

§36-1623. Purchase money mortgages.

An insurer may invest in purchase money mortgages or like securities, received by it upon the sale or exchange of real property theretofore owned by it. Provided, however, such investments shall be subject to the limitations of Section 1622 of this title.

Laws 1957, p. 290, § 1623.

§36-1624. Acquiring or holding real property.

No insurance company, foreign, alien or domestic, doing business in Oklahoma, may acquire or hold real property therein, except as follows:

1. Such as shall be requisite for the convenient accommodation of the transaction of its own business; the amount invested in such real property shall not exceed ten percent (10%) of the investing company's admitted assets but the Insurance Commissioner may grant permission to the company to invest in real property for such purpose in such increased amount as the Insurance Commissioner may deem proper on the showing made, if upon a hearing held the Insurance Commissioner finds that the amount represented by such percentage of its admitted assets is insufficient to provide convenient accommodation for the company's business. Real estate maintained for the convenient accommodation of the transaction of its own business, permitted to be carried as an admitted asset of the company pursuant to this section shall be carried at an amount equal to its cost at the time of acquisition together with the actual cost of improvements made thereon, less encumbrances and less depreciation; provided, however, any real estate carried at fair market value as an admitted asset of the company on November 1, 1989, shall be excluded from this provision;

2. Such as shall have been mortgaged to it in good faith by way of security for loans previously contracted for monies due;

3. Such as shall have been conveyed to it in satisfaction of debts previously contracted in course of its dealings;

4. Such as shall have been purchased at sales on judgments, decrees, or mortgages obtained or made for such debts;

5. Such real property as shall have been acquired in whole or in part, in exchange for real property of approximately the same value theretofore legally acquired and held by it;

6. Real property and improvements thereon located in incorporated cities and towns and as additions thereto or real property and improvements wherever located acquired for sale or lease, if such lessee or purchaser could have legally acquired the same in the first instance, and may make improvements thereon for commercial and industrial purposes as an investment for the production of income. The phrase "commercial and industrial purposes" shall not include real property primarily intended for use

or valued as agricultural, horticultural, farm, and ranch, unless adjacent to other real property the ownership of which is permitted under this section and was acquired prior to July 1, 2006. The total amount invested in such real property and improvements thereon shall not exceed the company's capital and/or surplus, or ten percent (10%) of its admitted assets whichever is the lesser; provided, however, the amount invested in any one investment shall not exceed four percent (4%) of the company's admitted assets. The admitted assets shall be determined by the company's last annual report made as of December 31, immediately preceding and which has been filed with the Insurance Commissioner as required by law, or as shown by a current financial statement on file with the Commissioner;

7. Real property acquired and held under Section 1612.1 of this title; and

8. Subject to specific limitations otherwise applicable, no more than an aggregate of thirty-five percent (35%), except as provided in paragraph 1 of subsection C of Section 1622 of this title, of the company's admitted assets may be invested in real property pursuant to this section, purchase money mortgages pursuant to Section 1623 of this title, and mortgage loans pursuant to Section 1622 of this title.

Added by Laws 1957, p. 290, § 1624, operative July 1, 1957. Amended by Laws 1965, c. 123, § 16; Laws 1989, c. 181, § 5, eff. Nov. 1, 1989; Laws 2006, c. 264, § 50, eff. July 1, 2006; Laws 2017, c. 287, § 4, eff. Nov. 1, 2017; Laws 2021, c. 274, § 2, emerg. eff. April 27, 2021.

§36-1625. Time limits for disposal of other ineligible property and securities; penalty.

A. Any personal property or securities lawfully acquired by an insurer, which it could not otherwise have invested in or loaned its funds upon at the time of such acquisition, shall be disposed of within three (3) years from date of acquisition, unless within such period the security has attained to the standard of eligibility; the failure to make such disposition shall result in the disallowance of such property as an asset in any statement by an insurer to the Insurance Commissioner, in any published financial statement or in any examiner's report to said Commissioner; provided, however, that any security or property acquired under any agreement of bulk reinsurance, merger, or consolidation may be retained for a longer period than such three (3) years if so provided in such plan for the reinsurance, merger, or consolidation as was approved by the Insurance Commissioner pursuant to this Code. The Insurance Commissioner, upon application and proof that forced sale of any such property or security would be against the best interests of the

insurer, may extend the disposal period for an additional reasonable time.

B. Any real property acquired in satisfaction of debt by an insurer, which the insurer could not otherwise have invested in or loaned funds upon at the time of such acquisition, shall be disposed of within three (3) years from the date of such acquisition. The Insurance Commissioner, upon application and proof that forced sale of any such property would be against the best interests of the insurer, may extend the disposal period for an additional reasonable time.

C. Any such real or personal property or security held by an insurer after expiration of the period for disposal thereof or any extension of such period granted by the Insurance Commissioner shall not be allowed as an asset of the insurer.
Laws 1957, p. 291, § 1625.

§36-1626. Investments of foreign, alien insurers.

The investments of a foreign or alien insurer shall be as permitted by the laws of its domicile but shall be of a quality substantially as high as those required under this article for similar funds of like domestic insurers.
Laws 1957, p. 291, § 1626.

§36-1627. Investments in loans secured by certain securities.

An insurer may invest in loans with a maturity not in excess of five (5) years from the date thereof which are secured by pledge of securities eligible for investment under this chapter, or by the pledge or assignment of life insurance policies issued by other insurers authorized to transact insurance in this state. On the date made, no such loan shall exceed in amount eighty percent (80%) of the market value of the collateral pledged.
Laws 1965, c. 123, § 17.

§36-1628. Definitions - Deposit of securities - Custodial responsibilities.

A. As used in this section:

1. "Agent" shall mean a national bank, state bank, or trust company which maintains an account in its name in a clearing corporation or which is a member of the Federal Reserve System and through which a custodian participates in a clearing corporation or the Federal Reserve book-entry system, except that with respect to securities issued by institutions organized or existing under the laws of any foreign country or securities used to meet the deposit requirements pursuant to the laws of a foreign country as a condition of doing business therein, "agent" may, with the prior approval of the Commissioner, include a corporation which is organized or existing under the laws of any foreign country and

which is legally qualified under such law to accept custody of securities;

2. "Clearing corporation" shall mean a corporation as defined in paragraph (5) of subsection (a) of Section 8-102 of Title 12A of the Oklahoma Statutes which is organized for the purpose of effecting transactions in securities by computerized book-entry, except that with respect to securities issued by institutions organized or existing under the laws of any foreign country or securities used to meet the deposit requirements pursuant to the laws of a foreign country as a condition of doing business therein, "clearing corporation" may include a corporation which is organized or existing under the laws of any foreign country and which is legally qualified under such laws to effect transactions in securities by computerized book-entry. The term "clearing corporation" also includes "Treasury/Reserve Automated Debt Entry Securities System" and "Treasury Direct" book-entry securities systems established pursuant to 31 U.S.C., Section 3100 et seq., 12 U.S.C. pt. 391 and 5 U.S.C. pt. 301. Clearing corporations shall have been approved for use by the Commissioner;

3. "Commissioner" shall mean the Insurance Commissioner of the State of Oklahoma or an authorized representative;

4. "Custodian" shall mean a national bank, state bank, or trust company which has at all times aggregate capital, surplus, and undivided profits of not less than Five Hundred Thousand Dollars (\$500,000.00) and which is regulated by either state banking laws or is a member of the Federal Reserve System and which is legally qualified to accept custody of securities in accordance with the standards set forth below, or a broker-dealer as defined by Section 1-102 of Title 71 of the Oklahoma Statutes that is registered with and subject to the jurisdiction of the Securities and Exchange Commission, maintains membership in the Securities Investor Protection Corporation, and has a tangible net worth equal to or greater than Two Hundred Fifty Million Dollars (\$250,000,000.00), except that with respect to securities issued by institutions organized or existing under the laws of any foreign country, or securities used to meet the deposit requirements pursuant to the laws of a foreign country as a condition of doing business therein, "custodian" may include a bank, trust company, or similar institution which has at all times aggregate capital, surplus, and undivided profits of not less than the equivalent of Five Hundred Thousand Dollars (\$500,000.00) and which is legally qualified to accept custody of securities;

5. "Federal Reserve book-entry system" shall mean the computerized systems sponsored by the United States Department of the Treasury and certain agencies and instrumentalities of the United States for holding and transferring securities of the United States government and the agencies and instrumentalities,

respectively, in Federal Reserve Banks through banks which are members of the Federal Reserve System or which otherwise have access to the computerized systems; and

6. "Securities" shall mean certificated securities and uncertificated securities as defined in paragraphs (4) and (18) of subsection (a) of Section 8-102 of Title 12A of the Oklahoma Statutes.

B. 1. a. Notwithstanding any other provision of law, a domestic insurance company may deposit or arrange for the deposit of securities held in or purchased for its general account and its separate accounts in a clearing corporation or the Federal Reserve book-entry system. When securities are deposited with a clearing corporation, certificates representing securities of the same class of the same issuer may be merged and held in bulk in the name of the nominee of the clearing corporation with any other securities deposited with the clearing corporation by any person, regardless of the ownership of the securities, and certificates representing securities of small denominations may be merged into one or more certificates of larger denominations. The records of any agent through which an insurance company holds securities in the Federal Reserve book-entry system, and the records of any custodian banks through which an insurance company holds securities in a clearing corporation, shall at all times show that the securities are held for the insurance company and for which accounts thereof.

b. Ownership of, and other interests in, the securities may be transferred by bookkeeping entry on the books of the clearing corporation or in the Federal Reserve book-entry system without, in either case, physical delivery of certificates representing such securities; and

2. Notwithstanding any other provision of law, securities eligible for deposit under the Oklahoma Insurance Code relating to deposit of securities by an insurance company as a condition of commencing or continuing to do an insurance business in this state may be deposited with a clearing corporation or held in the Federal Reserve book-entry system and used to meet the deposit requirements under the Oklahoma Insurance Code and shall be under the control of the Commissioner and shall not be withdrawn by the insurance company without the approval of the Commissioner. Any insurance company holding securities in this manner shall provide to the Commissioner evidence issued by its custodian or an agent through which the insurance company has deposited securities with a clearing

corporation or held in the Federal Reserve book-entry system, respectively, in order to establish that the securities are actually recorded in an account in the name of the custodian or agent and evidence that the records of the custodian or agent reflect that the securities are held subject to the order of the Commissioner.

C. 1. An insurance company may, by written agreement with a custodian, provide for the custody of its securities with a custodian, which securities may be held by the custodian or its agent or in a clearing corporation or in the Federal Reserve book-entry system. Securities so held, whether held by the custodian or its agent or in a clearing corporation or in the Federal Reserve book-entry system, are referred to herein as "custodied securities";

2. Any such agreement shall be in writing and shall be authorized by a resolution of the board of directors of the insurance company or of an authorized committee thereof. The terms of the agreement shall comply with the following:

- a. certified securities held by the custodian shall be held either separate from the securities of the custodian and of all of its other customers or in a fungible bulk of securities as part of a Filing of Securities by Issue (FOSBI) arrangement,
- b. securities held in a fungible bulk by the custodian and securities in a clearing corporation or in the Federal Reserve book-entry system shall be separately identified on the custodian's official records as being owned by the insurance company. The records shall identify which custodied securities are held by the custodian or by its agent and which securities are in a clearing corporation or in the Federal Reserve book-entry system. If the securities are in a clearing corporation or in the Federal Reserve book-entry system, the records shall also identify where the securities are and if in a clearing corporation, the name of the clearing corporation and if through an agent, the name of the agent,
- c. all custodied securities that are registered shall be registered in the name of the company or in the name of a nominee of the company or in the name of the custodian or its nominee or, if in a clearing corporation, in the name of the clearing corporation or its nominee,
- d. custodied securities shall be held subject to the instructions of the insurance company and shall be withdrawable upon the demand of the insurance company, except that custodied securities used to meet the deposit requirements set forth in the Insurance Code shall, to the extent required by the Code, be under

- the control of the Commissioner and shall not be withdrawn by the insurance company without the approval of the Commissioner,
- e. the custodian shall be required to send or cause to be sent to the insurance company a confirmation of all transfers of custodied securities to or from the account of the insurance company. In addition, the custodian shall be required to furnish the insurance company with reports of holdings of custodied securities at such times and containing such information as may be reasonably requested by the insurance company,
 - f. during the course of the custodian's regular business hours, any officer or employee of the insurance company, any independent accountant selected by the insurance company, and any representative of an appropriate regulatory body shall be entitled to examine, on the premises of the custodian, the custodian's records relating to custodied securities, but only upon furnishing the custodian with written instructions to that effect from an appropriate officer of the insurance company,
 - g. the custodian and its agents shall be required to send to the insurance company
 - (1) all reports which they receive from a clearing corporation or the Federal Reserve book-entry system on their respective systems of internal accounting control, and
 - (2) any reports prepared by outside auditors on the custodian's or its agents' internal accounting control of custodied securities that the insurance company may reasonably request,
 - h. the custodian shall maintain records sufficient to determine and verify information relating to custodied securities that may be reported in the insurance company's annual statement and supporting schedules and information required in any audit of the financial statements of the insurance company,
 - i. the custodian shall provide, upon written request from an appropriate officer of the insurance company, the appropriate affidavits, substantially in the form provided in subsections F, G and H of this section, with respect to custodied securities,
 - j. the custodian shall be obligated to indemnify the insurance company for any loss of custodied securities occasioned by the negligence or dishonesty of the custodian's officers and employees, or burglary,

- robbery, holdup, theft or mysterious disappearance, including loss by damage or destruction,
- k. in the event that there is a loss of custodied securities for which the custodian shall be obligated to indemnify the insurance company as provided in subparagraph j of this paragraph, the custodian shall promptly replace the securities or the value thereof and the value of any loss of rights or privileges resulting from said loss of securities,
 - l. the agreement may provide that the custodian will not be liable for any failure to take any action required to be taken under the agreement in the event and to the extent that the taking of such action is prevented or delayed by war (whether declared or not and including existing wars), revolution, insurrection, riot, civil commotion, act of God, accident, fire, explosion, stoppage of labor, strikes or other differences with employees, laws, regulations, orders or other acts of any governmental authority, or any other cause whatever beyond its reasonable control, and
 - m. in the event that the custodian gains entry in a clearing corporation or in the Federal Reserve book-entry system through an agent, there shall be an agreement between the custodian and the agent under which the agent shall be subject to the same liability for loss of custodied securities as the custodian, provided, however, that, if the agent shall be subject to regulation under the laws of a jurisdiction which is different from the jurisdiction the laws of which regulate the custodian, the Commissioner may accept a standard of liability applicable to the agent which is different from the standard of liability applicable to the custodian.

D. A company may loan stocks or obligations held by it pursuant to the provisions of this act to a broker-dealer registered under the Securities Exchange Act of 1934 or a member bank. The loan must be evidenced by a written agreement which provides that:

1. The loan will be fully collateralized by cash or obligations issued or guaranteed by the United States or an agency or an instrumentality thereof, and the collateral will be adjusted each business day during the term of the loan to maintain the required collateralization in the event of market value changes in the loaned securities or collateral;

2. The loan may be terminated by the company at any time, and the borrower will return the loaned stocks or obligations or their equivalent within five (5) business days after termination; and

3. The company has the right to retain the collateral or use the collateral to purchase investments equivalent to the loaned securities if the borrower defaults under the terms of the agreement and the borrower remains liable for any losses and expenses incurred by the company due to default that are not covered by the collateral.

E. An investment may consist of an individual interest in a pool of obligations or a fractional interest in a single obligation if the certificate of participation or interest or the confirmation of participation or interest in the investment shall be issued in the name of the company or the name of the custodian bank or the nominee of either and the certificate or confirmation must, if held by a custodian bank, be kept separate and apart from the investments of others so that at all times the participation may be identified as belonging solely to the company making the investment.

F. The following shall be substantially the form of custodian affidavit for use by a custodian bank where securities entrusted to its care have not been redeposited elsewhere:

FORM A

CUSTODIAN AFFIDAVIT

(For use by a custodian bank where securities entrusted to its care have not been redeposited elsewhere.)

STATE OF _____)

) ss

COUNTY OF _____)

_____, being duly sworn deposes and says that he or she is _____ of _____, a banking corporation organized under and pursuant to the laws of the _____ with the principal place of business at _____ (hereinafter called the "bank"):

That his or her duties involve supervision of activities of the bank as custodian and records relating thereto;

That the bank is custodian for certain securities of _____ having a place of business at _____

_____ (hereinafter called the "insurance company") pursuant to an agreement between the bank and the insurance company;

That the schedule attached hereto is a true and complete statement of securities (other than those caused to be deposited with The Depository Trust Company or like entity or a Federal Reserve Bank under the Federal Reserve book-entry procedure) which were in the custody of the bank for the account of the insurance company as of the close of business on _____; that, unless otherwise indicated on the schedule, the next maturing and all subsequent coupons were then either attached to coupon bonds or in the process of collection; and that, unless otherwise shown on the schedule, all such securities were in bearer form or in registered form in the

name of the insurance company or its nominee or of the bank or its nominee, or were in the process of being registered in such form; That the bank as custodian has the responsibility for the safekeeping of the securities as that responsibility is specifically set forth in the agreement between the bank as custodian and the insurance company; and

That, to the best of his or her knowledge and belief, unless otherwise shown on the schedule, the securities were the property of the insurance company and were free of all liens, claims, or encumbrances whatsoever.

Subscribed and sworn to
before me this _____ day
of _____ 19__

(L.S.)
Vice President (or other
authorized officer)

G. The following shall be substantially the form of custodian affidavit for use in instances where a custodian bank maintains securities on deposit with The Depository Trust Company or like entity:

FORM B

CUSTODIAN AFFIDAVIT

(For use in instances where a custodian bank maintains securities on deposit with The Depository Trust Company or like entity.)

STATE OF _____)

) ss

COUNTY OF _____)

_____, being duly sworn deposes and says that he or she is _____ of _____, a banking corporation organized under and pursuant to the laws of the _____ with the principal place of business at _____ (hereinafter called the "bank"):

That his or her duties involve supervision of activities of the bank as custodian and records relating thereto;

That the bank is custodian for certain securities of _____ with a place of business at _____ (hereinafter called the "insurance company") pursuant to an agreement between the bank and the insurance company;

That the bank has caused certain of such securities to be deposited with _____ and that the schedule attached hereto is a true and complete statement of the securities of the insurance company of which the bank was custodian as of the close of business on _____, and which were so deposited on such date;

That the bank as custodian has the responsibility for the safekeeping of the securities both in the possession of the bank or deposited with _____ as is specifically set forth in the

agreement between the bank as custodian and the insurance company;
and

That, to the best of his or her knowledge and belief, unless otherwise shown on the schedule, the securities were the property of the insurance company and were free of all liens, claims, or encumbrances whatsoever.

Subscribed and sworn to
before me this ____ day
of _____ 19__

(L.S.)
Vice President (or other
authorized officer)

H. The following shall be substantially the form of custodian affidavit for use where ownership is evidenced by book-entry at a Federal Reserve Bank:

FORM C
CUSTODIAN AFFIDAVIT

(For use where ownership is evidenced by book-entry at a Federal Reserve Bank.)

STATE OF _____)
_____) ss
COUNTY OF _____)

_____, being duly sworn deposes and says that he is _____ of the _____, a banking corporation organized under and pursuant to the laws of the _____ with the principal place of business at _____ (hereinafter called the "bank"):

That his or her duties involve supervision of activities of the bank as custodian and records relating thereto;

That the bank is custodian for certain securities of _____ with a place of business at _____ (hereinafter called the "insurance company") pursuant to an agreement between the bank and the insurance company;

That it has caused certain securities to be credited to its book-entry account with the Federal Reserve Bank of _____ under the Federal Reserve book-entry procedure; and that the schedule attached hereto is a true and complete statement of the securities of the insurance company of which the bank was custodian as of the close of business on _____ which were in a "General" book-entry account maintained in the name of the bank on the books and records of the Federal Reserve Bank of _____ at that date;

That the bank has the responsibility for the safekeeping of the securities both in the possession of the bank or in the "General" book-entry account as is specifically set forth in the agreement between the bank as custodian and the insurance company; and

That, to the best of his or her knowledge and belief, unless otherwise shown on the schedule, the securities were the property of the insurance company and were free of all liens, claims, or encumbrances whatsoever.

Subscribed and sworn to
before me this _____ day
of _____ 19__

(L.S.)
Vice President (or other
authorized officer)

Added by Laws 1983, c. 99, § 1, emerg. eff. May 9, 1983. Amended by Laws 1999, c. 141, § 4, eff. Nov. 1, 1999; Laws 2006, c. 98, § 1, eff. July 1, 2006.

§36-1629. Guaranteed or reinsured student loans.

Any insurer may make and invest in student loans guaranteed or reinsured as to principal and interest by a state or federally sponsored higher education assistance corporation, to the extent of such guaranty or reinsurance, or by a private nonprofit or for profit student loan insurance guarantor or reinsurer which has net worth of not less than Thirty-five Million Dollars (\$35,000,000.00) and which has a financial rating of BBB or better from Standard and Poor's or Moody's rating agencies. Any investment pursuant to this section shall not exceed, except with the consent of the Insurance Commissioner of this state, twenty-five percent (25%) of the insurer's net admitted assets based upon the insurer's most recent financial statement filed with the Insurance Commissioner's office. Added by Laws 1994, c. 142, § 1, eff. Sept. 1, 1994. Amended by Laws 1997, c. 418, § 87, eff. Nov. 1, 1997; Laws 2000, c. 100, § 1, eff. July 1, 2000.

§36-1631. Definitions.

As used in this act, the following terms shall have these meanings unless the context shall otherwise require:

1. "Affiliate of" or person "affiliated with" a specific person means 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;

2. "Commissioner" means the Insurance Commissioner of the State of Oklahoma, the Commissioner's deputies, or the Insurance Department, as appropriate;

3. "Control" includes the terms "controlling", "controlled by" and "under common control with" and 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 other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power

is the result of an official position 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 made in the manner provided by subsection K of Section 5 of this act that control does not exist in fact. The Commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support the determination that control exists in fact, notwithstanding the absence of a presumption to that effect;

4. "Group-wide supervisor" means the regulatory official authorized to engage in conducting and coordinating group-wide supervision activities who is determined or acknowledged by the Commissioner under Section 9 of this act to have sufficient significant contacts with the internationally active insurance group;

5. "Insurance holding company system" means an insurance holding company system consisting of two or more affiliated persons, one or more of which is an insurer;

6. "Insurer" has the same meaning as set forth in Section 103 of Title 36 of the Oklahoma Statutes, except that it shall not include agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state;

7. "Internationally active insurance group" means an insurance holding company system that:

- a. includes an insurer registered under Section 5 of this act, and
- b. meets the following criteria:
 - (1) premiums written in at least three countries,
 - (2) the percentage of gross premiums written outside the United States is at least ten percent (10%) of the insurance holding company system's total gross written premiums, and
 - (3) based on a three-year rolling average, the total assets of the insurance holding company system are at least Fifty Billion Dollars (\$50,000,000,000.00) or the total gross written premiums of the insurance holding company system are at least Ten Billion Dollars (\$10,000,000,000.00);

8. "Enterprise risk" means any activity, circumstance, event or series of events involving one or more affiliates of an insurer that, if not remedied promptly, is likely to have a material adverse effect upon the financial condition or liquidity of the insurer or

its insurance holding company system as a whole, including, but not limited to, anything that would cause the insurer's risk-based capital to fall into company action level as set forth in the Risk-based Capital for Insurers Act provided in Sections 1521 through 1533 of Title 36 of the Oklahoma Statutes, or would cause the insurer to be in hazardous financial condition pursuant to rules promulgated by the Insurance Department;

9. "Person" means an individual, a corporation, a limited liability company, a partnership, an association, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing acting in concert, but shall not include any joint venture partnership exclusively engaged in owning, managing, leasing or developing real or tangible personal property;

10. "Securityholder" of a specified person means one who owns any security of such person, including common stock, preferred stock, debt obligations and any other security convertible into or evidencing the right to acquire any of the foregoing;

11. "Subsidiary" of a specified person means an affiliate controlled by such person directly or indirectly through one or more intermediaries; and

12. "Voting security" means any security convertible into or evidencing a right to acquire a voting security.

Added by Laws 2017, c. 350, § 1, emerg. eff. May 31, 2017.

§36-1632. Subsidiaries of domestic insurers - Permissible investments.

A. A domestic insurer, either by itself or in cooperation with one or more persons, may organize or acquire one or more subsidiaries. The subsidiaries may conduct any kind of business or businesses and their authority to do so shall not be limited by reason of the fact that they are subsidiaries of a domestic insurer.

B. In addition to investments in common stock, preferred stock, debt obligations and other securities permitted under all other sections of Title 36 of the Oklahoma Statutes, a domestic insurer may also:

1. Invest in common stock, preferred stock, debt obligations and other securities of one or more subsidiaries, amounts which do not exceed the lesser of ten percent (10%) of the insurer's assets or fifty percent (50%) of the insurer's surplus as regards policyholders, provided that after such investments the insurer's surplus as regards policyholders will be reasonable in relation to the insurer's outstanding liabilities and adequate to meet its financial needs. In calculating the amount of such investments, investments in domestic or foreign insurance subsidiaries and any other entity which provides or arranges for the financing or provision of health care services or coverage over which the

Commissioner possesses financial solvency and regulatory oversight authority shall be excluded, and there shall be included:

- a. total net monies or other consideration expended and obligations assumed in the acquisition or formation of a subsidiary, including all organizational expenses and contributions to capital and surplus of the subsidiary whether or not represented by the purchase of capital stock or issuance of other securities, and
- b. all amounts expended in acquiring additional common stock, preferred stock, debt obligations and other securities, and all contributions to the capital or surplus of a subsidiary subsequent to its acquisition or formation;

2. Invest any amount in common stock, preferred stock, debt obligations and other securities of one or more subsidiaries engaged or organized to engage exclusively in the ownership and management of assets authorized as investments for the insurer provided that each subsidiary agrees to limit its investments in any asset so that such investments will not cause the amount of the total investment of the insurer to exceed any of the investment limitations specified in paragraph 1 of this subsection or in Sections 1601 through 1629 of Title 36 of the Oklahoma Statutes applicable to the insurer. For the purpose of this paragraph, "the total investment of the insurer" shall include:

- a. any direct investment by the insurer in an asset, and
- b. the insurer's proportionate share of any investment in an asset by any subsidiary of the insurer, which shall be calculated by multiplying the amount of the subsidiary's investment by the percentage of the ownership of the subsidiary; and

3. With the approval of the Commissioner, invest any greater amount in common stock, preferred stock, debt obligations or other securities of one or more subsidiaries, provided that after the investment the insurer's surplus as regards policyholders will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

C. Investments in common stock, preferred stock, debt obligations or other securities of subsidiaries made pursuant to subsection B of this section shall not be subject to any of the otherwise applicable restrictions or prohibitions contained in Title 36 of the Oklahoma Statutes applicable to such investments of insurers.

D. Whether any investment made pursuant to subsection B of this section meets the requirements of that subsection is to be determined before the investment is made, by calculating the applicable investment limitations as though the investment had already been made, taking into account the then outstanding

principal balance on all previous investments in debt obligations, and the value of all previous investments in equity securities as of the day they were made, net of any return of capital invested, not including dividends.

E. If an insurer ceases to control a subsidiary, it shall dispose of any investment therein made pursuant to this section within three (3) years from the time of the cessation of control or within such further time as the Commissioner may prescribe, unless at any time after the investment shall have been made, the investment shall have met the requirements for investment under any other section of Title 36 of the Oklahoma Statutes, and the insurer notifies the Commissioner.

Added by Laws 2017, c. 350, § 2, emerg. eff. May 31, 2017.

§36-1633. Acquisition of control of or merger with domestic insurer.

A. The requirements for filing shall be as follows:

1. No person other than the issuer shall make a tender offer for or a request or invitation for tenders of, or enter into any agreement to exchange securities for, seek to acquire, or acquire, in the open market or otherwise, any voting security of a domestic insurer if, after the consummation thereof, such person would, directly or indirectly, or by conversion or by exercise of any right to acquire, be in control of the insurer, and no person shall enter into an agreement to merge with or otherwise to acquire control of a domestic insurer or any person controlling a domestic insurer unless, at the time the offer, request or invitation is made or the agreement is entered into, or prior to the acquisition of the securities if no offer or agreement is involved, such person has filed with the Commissioner and has sent to the insurer, and such insurer has sent to its shareholders, a statement containing the information required by this section and the offer, request, invitation, agreement or acquisition has been approved by the Commissioner in the manner prescribed in this act;

2. For purposes of this section, any controlling person of a domestic insurer seeking to divest its controlling interest in the domestic insurer, in any manner, shall file with the Commissioner, with a copy to the insurer, confidential notice of its proposed divestiture at least thirty (30) days prior to the cessation of control. The Commissioner shall determine those instances in which the party or parties seeking to divest or to acquire a controlling interest in an insurer shall be required to file for and obtain approval of the transaction. The information shall remain confidential until the conclusion of the transaction unless the Commissioner, in his or her discretion, determines that confidential treatment will interfere with enforcement of this section. If the

statement referred to in paragraph 1 of this subsection is otherwise filed, this paragraph shall not apply;

3. With respect to a transaction subject to this section, the acquiring person must also file a preacquisition notification with the Commissioner, which shall contain the information set forth in paragraph 1 of subsection C of Section 4 of this act. A failure to file the notification may be subject to the penalty specified in paragraph 3 of subsection E of Section 4 of this act; and

4. For purposes of this section, a "domestic insurer" shall include any person controlling a domestic insurer unless the person, as determined by the Commissioner, is either directly or through its affiliates primarily engaged in business other than the business of insurance. For the purposes of this section, "person" shall not include any securities broker holding, in the usual and customary broker's function, less than twenty percent (20%) of the voting securities of an insurance company or of any person which controls an insurance company.

B. The statement to be filed with the Commissioner shall be made under oath or affirmation and shall contain the following:

1. The name and address of each person by whom or on whose behalf the merger or other acquisition of control referred to in subsection A of this section, hereinafter called the "acquiring party", is to be affected:

- a. if the person is an individual, his or her principal occupation and all offices and positions held during the past five (5) years, and any conviction of crimes other than minor traffic violations during the past ten (10) years, and
- b. if the person is not an individual, a report of the nature of its business operations during the past five (5) years or for the lesser period as the person and any predecessors shall have been in existence; an informative description of the business intended to be done by the person and the person's subsidiaries; and a list of all individuals who are or who have been selected to become directors or executive officers of the person, or who perform or will perform functions appropriate to such positions. The list shall include for each individual the information required by subparagraph a of this paragraph;

2. The source, nature and amount of the consideration used or to be used in effecting the merger or other acquisition of control, a description of any transaction where funds were or are to be obtained for any such purpose, including any pledge of the insurer's stock or the stock of any of its subsidiaries or controlling affiliates, and the identity of persons furnishing consideration; provided, however, that where a source of consideration is a loan

made in the lender's ordinary course of business, the identity of the lender shall remain confidential, if the person filing the statement so requests;

3. Fully audited financial information as to the earnings and financial condition of each acquiring party for the preceding five (5) fiscal years of each acquiring party, or for such lesser period as the acquiring party and any predecessors shall have been in existence, and similar unaudited information as of a date not earlier than ninety (90) days prior to the filing of the statement;

4. Any plans or proposals which each acquiring party may have to liquidate the insurer, to sell its assets or merge or consolidate it with any person, or to make any other material change in its business or corporate structure or management;

5. The number of shares of any security referred to in subsection A of this section which each acquiring party proposes to acquire, and the terms of the offer, request, invitation, agreement or acquisition referred to in subsection A of this section, and a statement as to the method by which the fairness of the proposal was arrived at;

6. The amount of each class of any security referred to in subsection A of this section which is beneficially owned or concerning which there is a right to acquire beneficial ownership by each acquiring party;

7. A full description of any contracts, arrangements or understandings with respect to any security referred to in subsection A of this section in which any acquiring party is involved, including but not limited to transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. The description shall identify the persons with whom the contracts, arrangements or understandings have been entered into;

8. A description of the purchase of any security referred to in subsection A of this section during the twelve (12) calendar months preceding the filing of the statement by any acquiring party, including the dates of purchase, names of the purchasers and consideration paid or agreed to be paid;

9. A description of any recommendations to purchase any security referred to in subsection A of this section made during the twelve (12) calendar months preceding the filing of the statement by any acquiring party, or by anyone based upon interviews or at the suggestion of the acquiring party;

10. Copies of all tender offers for, requests, or invitations for tenders of, exchange offers for, and agreements to acquire or exchange any securities referred to in subsection A of this section, and, if distributed, additional related soliciting material;

11. The term of any agreement, contract or understanding made with or proposed to be made with any broker-dealer as to solicitation of securities referred to in subsection A of this section for tender, and the amount of any fees, commissions or other compensation to be paid to broker-dealers with regard thereto;

12. An agreement by the person required to file the statement referred to in subsection A of this section that it will provide the annual report, specified in subsection L of Section 5 of this act, for so long as control exists;

13. An acknowledgement by the person required to file the statement referred to in subsection A of this section that the person and all subsidiaries within its control in the insurance holding company system will provide information to the Commissioner upon request as necessary to evaluate enterprise risk to the insurer; and

14. Such additional information as the Commissioner may by rule or regulation prescribe as necessary or appropriate for the protection of policyholders of the insurer or in the public interest. If the person required to file the statement referred to in subsection A of this section is a partnership, limited partnership, syndicate or other group, the Commissioner may require that the information required pursuant to paragraphs 1 through 14 of this subsection shall be given with respect to each partner of the partnership or limited partnership, each member of the syndicate or group, and each person who controls the partner or member. If any partner, member or person is a corporation or the person required to file the statement referred to in subsection A of this section is a corporation, the Commissioner may require that the information required pursuant to paragraphs 1 through 14 of this subsection shall be given with respect to the corporation, each officer and director of the corporation, and each person who is directly or indirectly the beneficial owner of more than ten percent (10%) of the outstanding voting securities of the corporation. If any material change occurs in the facts set forth in the statement filed with the Commissioner and sent to the insurer pursuant to this section, an amendment setting forth the change, together with copies of all documents and other material relevant to the change, shall be filed with the Commissioner and sent to the insurer within two (2) business days after the person learns of the change.

C. If any offer, request, invitation, agreement or acquisition referred to in subsection A of this section is proposed to be made by means of a registration statement under the Securities Act of 1933, or in circumstances requiring the disclosure of similar information under the Securities Exchange Act of 1934 or under a state law requiring similar registration or disclosure, the person required to file the statement referred to in subsection A of this

section may utilize the documents in furnishing the information called for by that statement.

D. 1. The Commissioner shall approve any merger or other acquisition of control referred to in subsection A of this section unless, after a public hearing, the Commissioner finds that:

- a. after the change of control, the domestic insurer referred to in subsection A of this section would not be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which it is presently licensed,
- b. the effect of the merger or other acquisition of control would be substantially to lessen competition in insurance in this state or tend to create a monopoly. In applying the competitive standard in this subparagraph:
 - (1) the informational requirements of paragraph 1 of subsection C of Section 4 of this act and the standards of paragraph 2 of subsection D of Section 4 of this act shall apply,
 - (2) the merger or other acquisition shall not be disapproved if the Commissioner finds that any of the situations meeting the criteria provided by paragraph 3 of subsection D of Section 4 of this act exist, and
 - (3) the Commissioner may condition the approval of the merger or other acquisition on the removal of the basis of disapproval within a specified period of time,
- c. the financial condition of any acquiring party is such as might jeopardize the financial stability of the insurer, or prejudice the interest of its policyholders,
- d. the plans or proposals which the acquiring party has to liquidate the insurer, sell its assets or consolidate or merge it with any person, or to make any other material change in its business or corporate structure or management, are unfair and unreasonable to policyholders of the insurer and not in the public interest,
- e. the competence, experience and integrity of those persons who would control the operation of the insurer are such that it would not be in the interest of policyholders of the insurer and of the public to permit the merger or other acquisition of control, or
- f. the acquisition is likely to be hazardous or prejudicial to the insurance-buying public.

2. The public hearing referred to in paragraph 1 of this subsection shall be held within thirty (30) days after the statement required by subsection A of this section is filed, and at least twenty (20) days' notice shall be given by the Commissioner to the person filing the statement. Not less than fourteen (14) days' notice of the public hearing shall be given by the person filing the statement to the insurer and to such other persons as may be designated by the Commissioner. The insurer shall give notice to its securityholders. The Commissioner shall make a determination within the sixty-day period preceding the effective date of the proposed transaction. At the hearing, the person filing the statement, the insurer, any person to whom notice of hearing was sent, and any other person whose interest may be affected shall have the right to present evidence, examine and cross-examine witnesses, and offer oral and written arguments and in connection therewith shall be entitled to conduct discovery proceedings in the same manner as is presently allowed by subsection A of Section 317 of Title 36 of the Oklahoma Statutes. All discovery proceedings shall be concluded not later than three (3) days prior to the commencement of the public hearing.

3. If the proposed acquisition of control will require the approval of more than one state's Commissioner, the public hearing referred to in paragraph 2 of this subsection may be held on a consolidated basis upon request of the person filing the statement referred to in subsection A of this section. Such person shall file the statement referred to in subsection A of this section with the National Association of Insurance Commissioners (NAIC) within five (5) days of making the request for a public hearing. The Commissioner may opt out of a consolidated hearing, and shall provide notice to the applicant of the opt-out within ten (10) days of the receipt of the statement referred to in subsection A of this section. A hearing conducted on a consolidated basis shall be public and shall be held within the United States before the Commissioners of the states in which the insurers are domiciled. Such Commissioners shall hear and receive evidence. A Commissioner may attend such hearing, in person or by telecommunication.

4. In connection with a change of control of a domestic insurer, any determination by the Commissioner that the person acquiring control of the insurer shall be required to maintain or restore the capital of the insurer to the level required by the laws and regulations of this state shall be made not later than sixty (60) days after the date of notification of the change in control submitted pursuant to paragraph 1 of subsection A of Section 3 of this act.

5. The Commissioner may retain at the acquiring person's expense any attorneys, actuaries, accountants and other experts not otherwise a part of the Commissioner's staff as may be reasonably

necessary to assist the Commissioner in reviewing the proposed acquisition of control.

E. The provisions of this section shall not apply to any offer, request, invitation, agreement or acquisition which the Commissioner by order shall exempt as not having been made or entered into for the purpose and not having the effect of changing or influencing the control of a domestic insurer, or as otherwise not comprehended within the purposes of this section.

F. The following shall be violations of this section:

1. The failure to file any statement, amendment or other material required to be filed pursuant to subsection A or B of this section; or

2. The effectuation or any attempt to effectuate an acquisition of control of, divestiture of, or merger with, a domestic insurer unless the Commissioner has given approval.

G. The courts of this state are hereby vested with jurisdiction over every person not resident, domiciled or authorized to do business in this state who files a statement with the Commissioner under this section, and overall actions involving such person arising out of violations of this section, and each such person shall be deemed to have performed acts equivalent to and constituting an appointment by the person of the Commissioner to be his true and lawful attorney upon whom may be served all lawful process in any action, suit or proceeding arising out of violations of this section. Copies of all lawful process shall be served on the Commissioner and transmitted by registered or certified mail by the Commissioner to the person at his or her last-known address. Added by Laws 2017, c. 350, § 3, emerg. eff. May 31, 2017.

§36-1634. Acquisitions leading to change in control of an insurer - Exceptions - Examination by Commissioner.

A. The following definitions shall apply for the purposes of this section only:

1. "Acquisition" means any agreement, arrangement or activity the consummation of which results in a person acquiring directly or indirectly the control of another person, and includes but is not limited to the acquisition of voting securities, the acquisition of assets, bulk reinsurance and mergers; and

2. "Involved insurer" includes an insurer which acquires or is acquired, is affiliated with an acquirer or acquired, or is the result of a merger.

B. 1. Except as exempted in paragraph 2 of this subsection, this section applies to any acquisition in which there is a change in control of an insurer authorized to do business in this state.

2. This section shall not apply to the following:

a. a purchase of securities solely for investment purposes so long as the securities are not used by

voting or otherwise to cause or attempt to cause the substantial lessening of competition in any insurance market in this state. If a purchase of securities results in a presumption of control under paragraph 3 of Section 1 of this act, it is not solely for investment purposes unless the Commissioner of the insurer's state of domicile accepts a disclaimer of control or affirmatively finds that control does not exist and the disclaimer action or affirmative finding is communicated by the domiciliary Commissioner to the Commissioner of this state,

- b. the acquisition of a person by another person when both persons are neither directly nor through affiliates primarily engaged in the business of insurance, if preacquisition notification is filed with the Commissioner in accordance with paragraph 1 of subsection C of this section thirty (30) days prior to the proposed effective date of the acquisition. However, such preacquisition notification is not required for exclusion from this section if the acquisition would otherwise be excluded from the requirements of this section by any other subparagraph of this paragraph,
- c. the acquisition of already affiliated persons,
- d. an acquisition if, as an immediate result of the acquisition,
 - (1) in no market would the combined market share of the involved insurers exceed five percent (5%) of the total market,
 - (2) there would be no increase in any market share, or
 - (3) in no market would:
 - (a) the combined market share of the involved insurers exceed twelve percent (12%) of the total market, and
 - (b) the market share increase by more than two percent (2%) of the total market.

For the purpose of this subparagraph, a "market" means direct written insurance premium in this state for a line of business as contained in the annual statement required to be filed by insurers licensed to do business in this state,

- e. an acquisition for which a preacquisition notification would be required pursuant to this section due solely to the resulting effect on the ocean marine insurance line of business, and

- f. an acquisition of an insurer whose domiciliary Commissioner affirmatively finds that the insurer is in failing condition; there is a lack of feasible alternative to improving such condition; the public benefits of improving the insurer's condition through the acquisition exceed the public benefits that would arise from not lessening competition; and the findings are communicated by the domiciliary Commissioner to the Commissioner of this state.

C. Any acquisition described in subsection B of this section may be subject to an order pursuant to subsection E of this section unless the acquiring person files a preacquisition notification and the waiting period has expired. The acquired person may file a preacquisition notification. The Commissioner shall give confidential treatment to information submitted under this subsection in the same manner as provided in Section 10 of this act.

1. The preacquisition notification shall be in such form and contain such information as prescribed by the National Association of Insurance Commissioners (NAIC) relating to those markets which, under subparagraph d of paragraph 2 of subsection B of this section, cause the acquisition not to be exempted from the provisions of this section. The Commissioner may require such additional material and information as deemed necessary to determine whether the proposed acquisition, if consummated, would violate the competitive standard of subsection D of this section. The required information may include an opinion of an economist as to the competitive impact of the acquisition in this state accompanied by a summary of the education and experience of such person indicating his or her ability to render an informed opinion.

2. The waiting period required shall begin on the date of receipt of the Commissioner of a preacquisition notification and shall end on the earlier of the thirtieth day after the date of receipt, or termination of the waiting period by the Commissioner. Prior to the end of the waiting period, the Commissioner on a one-time basis may require the submission of additional needed information relevant to the proposed acquisition, in which event the waiting period shall end on the earlier of the thirtieth day after receipt of the additional information by the Commissioner or termination of the waiting period by the Commissioner.

D. 1. The Commissioner may enter an order under paragraph 1 of subsection E of this section with respect to an acquisition if there is substantial evidence that the effect of the acquisition may be substantially to lessen competition in any line of insurance in this state or tend to create a monopoly or if the insurer fails to file adequate information in compliance with subsection C of this section.

2. In determining whether a proposed acquisition would violate the competitive standard of paragraph 1 of this subsection, the Commissioner shall consider the following:

a. any acquisition covered under subsection B of this section involving two or more insurers competing in the same market is evidence of violation of the competitive standards.

(1) if the market is highly concentrated and the involved insurers possess the following shares of the market:

Insurer A	Insurer B
4%	4% or more
10%	2% or more
15%	1% or more, or

(2) if the market is not highly concentrated and the involved insurers possess the following shares of the market:

Insurer A	Insurer B
5%	5% or more
10%	4% or more
15%	3% or more
19%	1% or more

A highly concentrated market, for purposes of this subparagraph, is one in which the share of the four largest insurers is seventy-five percent (75%) or more of the market. Percentages not shown in the tables are interpolated proportionately to the percentages that are shown. If more than two insurers are involved, exceeding the total of the two columns in the table is prima facie evidence of violation of the competitive standard in paragraph 1 of this subsection. For the purpose of this subparagraph, the insurer with the largest share of the market shall be deemed to be Insurer A,

b. there is a significant trend toward increased concentration when the aggregate market share of any grouping of the largest insurers in the market, from the two largest to the eight largest, has increased by seven percent (7%) or more of the market over a period of time extending from any base year five (5) to ten (10) years prior to the acquisition up to the time of the acquisition. Any acquisition or merger covered under subsection B of Section 5 of this act involving two or more insurers competing in the same market is evidence of violation of the competitive standard in paragraph 1 of this subsection if:

- (1) there is a significant trend toward increased concentration in the market,
 - (2) one of the insurers involved is one of the insurers in a grouping of large insurers showing the requisite increase in the market share, and
 - (3) another involved insurer's market is two percent (2%) or more,
- c. for the purposes of this paragraph:
- (1) the term "insurer" includes any company or group of companies under common management, ownership or control,
 - (2) the term "market" means the relevant product and geographical markets. In determining the relevant product and geographical markets, the Commissioner shall give due consideration to, among other things, the definitions or guidelines, if any, promulgated by the NAIC and to information, if any, submitted by parties to the acquisition. In the absence of sufficient information to the contrary, the relevant product market is assumed to be the direct written insurance premium for a line of business, such line being that used in the annual statement required to be filed by insurers doing business in this state, and the relevant geographical market is assumed to be this state,
 - (3) the burden of showing prima facie evidence of violation of the competitive standard rests upon the Commissioner, and
- d. even though an acquisition is not a prima facie violation of the competitive standard under subparagraphs a and b of this paragraph, the Commissioner may establish the requisite anticompetitive effect based upon other substantial evidence. Even though an acquisition is a prima facie violation of the competitive standard under subparagraphs a and b of this paragraph, a party may establish the absence of the requisite anticompetitive effect based upon other substantial evidence. Relevant factors in making a determination under this subparagraph include, but are not limited to, market shares, volatility of ranking of market leaders, number of competitors, concentration, trend of concentration in the industry, and ease of entry and exit into the market.

3. An order may not be entered under subsection E of this section if:

- a. the acquisition will yield substantial economies of scale or economies in resource utilization that cannot be feasibly achieved in any other way, and the public benefits which would arise from such economies exceed the public benefits which would arise from not lessening competition, or
 - b. the acquisition will substantially increase the availability of insurance, and the public benefits of the increase exceed the public benefits which would arise from not lessening competition.
- E. 1. a. If an acquisition violates the standards of this section, the Commissioner may enter an order:
- (1) requiring an involved insurer to cease and desist from doing business in this state with respect to the line or lines of insurance involved in the violation, or
 - (2) denying the application of an acquired or acquiring insurer for a license to do business in this state.
- b. The order shall not be entered unless:
- (1) there is a hearing,
 - (2) notice of the hearing is issued prior to the end of the waiting period and not less than fifteen (15) days prior to the hearing, and
 - (3) the hearing is concluded and the order is issued no later than sixty (60) days after the date of the filing of the preacquisition notification with the Commissioner.
- c. Every order shall be accompanied by a written decision of the Commissioner setting forth findings of fact and conclusions of law.
- d. An order pursuant to this paragraph shall not apply if the acquisition is not consummated.

2. Any person who violates a cease and desist order of the Commissioner under paragraph 1 of this subsection and while the order is in effect may, after notice and hearing and upon order of the Commissioner, be subject at the discretion of the Commissioner to one or more of the following:

- a. a monetary penalty of not more than Ten Thousand Dollars (\$10,000.00) for every day of violation, or
- b. suspension or revocation of the person's license.

3. Any insurer or other person who fails to make any filing required by this section, and who also fails to demonstrate a good-faith effort to comply with any filing requirement, shall be subject to a fine of not more than Fifty Thousand Dollars (\$50,000.00).

F. Subsections B and C of Section 12 of this act and Section 14 of this act shall not apply to acquisitions covered under subsection B of this section.

Added by Laws 2017, c. 350, § 4, emerg. eff. May 31, 2017.

§36-1635. Registration of insurers.

A. Every insurer which is authorized to do business in this state and which is a member of an insurance holding company system shall register with the Commissioner, except a foreign insurer subject to registration requirements and standards adopted by statute or regulation in the jurisdiction of its domicile which are substantially similar to those contained in:

1. This section;

2. Paragraph 1 of subsection A of Section 6 of this act and subsections B and D of Section 6 of this act; and

3. Either paragraph 2 of subsection A of Section 6 of this act or a provision such as the following: Each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions within fifteen (15) days after the end of the month in which it learns of each change or addition; provided, however, that subject to subsection B of Section 6 of this act, each registered insurer shall so report all dividends and other distributions to shareholders within two (2) business days following the declaration thereof.

Any insurer which is subject to registration under this section shall register within fifteen (15) days after it becomes subject to registration, and annually thereafter by May 1 of each year for the previous calendar year, unless the Commissioner for good cause shown extends the time for registration, and then within the extended time. The Commissioner may require any insurer authorized to do business in the state which is a member of an insurance holding company system, and which is not subject to registration under this section, to furnish a copy of the registration statement, the summary specified in subsection C of this section or other information filed by the insurance company with the insurance regulatory authority of its domiciliary jurisdiction.

B. Every insurer subject to registration shall file the registration statement with the Commissioner on a form and in a format prescribed by the National Association of Insurance Commissioners, which shall contain the following current information:

1. The capital structure, general financial condition, ownership and management of the insurer and any person controlling the insurer;

2. The identity and relationship of every member of the insurance holding company system;

3. The following agreements in force, and transactions currently outstanding or which have occurred during the last calendar year between the insurer and its affiliates:

- a. loans, other investments, or purchases, sales or exchanges of securities of the affiliates by the insurer or of the insurer by its affiliates,
- b. purchases, sales or exchange of assets,
- c. transactions not in the ordinary course of business,
- d. guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the insurer's assets to liability, other than insurance contracts entered into in the ordinary course of the insurer's business,
- e. all management agreements, service contracts and all cost-sharing arrangements,
- f. reinsurance agreements,
- g. dividends and other distributions to shareholders, and
- h. consolidated tax allocation agreements;

4. Any pledge of the insurer's stock, including stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system;

5. If requested by the Commissioner, the insurer shall include financial statements of or within an insurance holding company system, including all affiliates. Financial statements may include but are not limited to annual audited financial statements filed with the U.S. Securities and Exchange Commission (SEC) pursuant to the Securities Act of 1933, as amended, or the Securities Exchange Act of 1934, as amended. An insurer required to file financial statements pursuant to this paragraph may satisfy the request by providing the Commissioner with the most recently filed parent corporation financial statements that have been filed with the SEC;

6. Other matters concerning transactions between registered insurers and any affiliates as may be included from time to time in any registration forms adopted or approved by the Commissioner;

7. Statements that the insurer's board of directors oversees corporate governance and internal controls and that the insurer's officers or senior management have approved, implemented and continue to maintain and monitor corporate governance and internal control procedures; and

8. Any other information required by the Commissioner by rule or regulation.

C. All registration statements shall contain a summary outlining all items in the current registration statement representing changes from the prior registration statement.

D. No information need be disclosed on the registration statement filed pursuant to subsection B of this section if the information is not material for the purposes of this section.

Unless the Commissioner by rule, regulation or order provides otherwise, sales, purchases, exchanges, loans or extensions of credit, investments, or guarantees involving one-half of one percent (.5%) or less of an insurer's admitted assets as of December 31 next preceding shall not be deemed material for purposes of this section.

E. Subject to subsection B of Section 6 of this act, each registered insurer shall report to the Commissioner all dividends and other distributions to shareholders within fifteen (15) business days following the declaration thereof.

F. Any person within an insurance holding company system subject to registration shall be required to provide complete and accurate information to an insurer, where the information is reasonably necessary to enable the insurer to comply with the provisions of this act.

G. The Commissioner shall terminate the registration of any insurer which demonstrates that it no longer is a member of an insurance holding company system.

H. The Commissioner may require or allow two or more affiliated insurers subject to registration to file a consolidated registration statement.

I. The Commissioner may allow an insurer which is authorized to do business in this state and which is part of an insurance holding company system to register on behalf of any affiliated insurer which is required to register under subsection A of this section and to file all information and material required to be filed under this section.

J. The provisions of this section shall not apply to any insurer, information or transaction if and to the extent that the Commissioner by rule, regulation or order shall exempt the same from the provisions of this section.

K. Any person may file with the Commissioner a disclaimer of affiliation with any authorized insurer or a disclaimer may be filed by the insurer or any member of an insurance holding company system. The disclaimer shall fully disclose all material relationships and bases for affiliation between the person and the insurer as well as the basis for disclaiming the affiliation. A disclaimer of affiliation shall be deemed to have been granted unless the Commissioner, within thirty (30) days following receipt of a complete disclaimer, notifies the filing party the disclaimer is disallowed. In the event of disallowance, the disclaiming party may request an administrative hearing, which shall be granted. The disclaiming party shall be relieved of its duty to register under this section if approval of the disclaimer has been granted by the Commissioner, or if the disclaimer is deemed to have been approved.

L. The ultimate controlling person of every insurer subject to registration shall also file an annual enterprise risk report. The report shall, to the best of the ultimate controlling person's

knowledge and belief, identify the material risks within the insurance holding company system that could pose enterprise risk to the insurer. The report shall be filed with the lead state Commissioner of the insurance holding company system as determined by the procedures within the Financial Analysis Handbook adopted by the National Association of Insurance Commissioners.

M. The failure to file a registration statement or any summary of the registration statement or enterprise risk filing required by this section within the time specified for filing shall be a violation of this section.

Added by Laws 2017, c. 350, § 5, emerg. eff. May 31, 2017.

§36-1636. Transactions within an insurance holding company - Standards.

A. 1. Transactions within an insurance holding company system to which an insurer subject to registration is a party shall be subject to the following standards:

- a. the terms shall be fair and reasonable,
- b. agreements for cost-sharing services and management shall include such provisions as required by rule and regulation issued by the Commissioner,
- c. charges or fees for services performed shall be reasonable,
- d. expenses incurred and payment received shall be allocated to the insurer in conformity with customary insurance accounting practices consistently applied,
- e. the books, accounts and records of each party to all such transactions shall be so maintained as to clearly and accurately disclose the nature and details of the transactions including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties,
- f. the insurer's surplus as regards policyholders following any dividends or distributions to shareholder affiliates shall be reasonable in relation to the insurer's outstanding liabilities and adequate to meet its financial needs,
- g. if an insurer subject to this act is deemed by the Commissioner to be in a hazardous financial condition as defined by Section 1905 of this title and applicable regulations in Title 365 of the Oklahoma Administrative Code or a condition that would be grounds for supervision, conservation, or a delinquency proceeding, then the Commissioner may require the insurer to secure and maintain from any affiliate with whom the insurer has services or management agreements either a deposit, held by the

Commissioner, or a bond, as determined by the insurer at the insurer's discretion, for the protection of the insurer for the duration of the contract(s) or agreement(s), or the existence of the condition for which the Commissioner required the deposit or the bond. In determining whether a deposit or a bond is required, the Commissioner should consider whether concerns exist with respect to the affiliated person's ability to fulfill the contract(s) or agreement(s) if the insurer were to be put into liquidation. Once the insurer is deemed to be in a hazardous financial condition or a condition that would be grounds for supervision, conservation, or a delinquency proceeding, and a deposit or bond is necessary, the Commissioner has discretion to determine the amount of the deposit or bond, not to exceed the value of the contract(s) or agreement(s) in any one (1) year, and whether such deposit or bond should be required for a single contract, multiple contracts, or a contract only with a specific person(s),

- h. all records and data of the insurer held by an affiliate are and remain the property of the insurer, are subject to control of the insurer, are identifiable, and are segregated or readily capable of segregation, at no additional cost to the insurer, from all other persons' records and data. This includes all records and data that are otherwise the property of the insurer, in whatever form maintained, including, but not limited to, claims and claim files, policyholder lists, application files, litigation files, premium records, rate books, underwriting manuals, personnel records, financial records, or similar records within the possession, custody, or control of the affiliate. At the request of the insurer, the affiliate shall provide that the receiver can obtain a complete set of all records of any type that pertain to the insurer's business; obtain access to the operating systems on which the data is maintained; obtain the software that runs those systems either through assumption of licensing agreements or otherwise; and restrict the use of the data by the affiliate if it is not operating the insurer's business. The affiliate shall provide a waiver of any landlord lien or other encumbrance to give the insurer access to all records and data in the event of the affiliate's default under a lease or other agreement, and

- i. premiums or other funds belonging to the insurer that are collected by or held by an affiliate are the exclusive property of the insurer and are subject to the control of the insurer. Any right of offset in the event an insurer is placed into receivership shall be subject to Article 19 of this title regarding rehabilitation and liquidation of insurers.

2. The following transactions involving a domestic insurer and any person in its insurance holding company system, including amendments or modifications of affiliate agreements previously filed pursuant to this section, which are subject to any materiality standards contained in subparagraphs a through g of this paragraph, shall not be entered into unless the insurer has notified the Commissioner in writing of its intention to enter into the transaction at least thirty (30) days prior thereto, or such shorter period as the Commissioner may permit, and the Commissioner has not disapproved it within that period. The notice for amendments or modifications shall include the reasons for the change and the financial impact on the domestic insurer. Informal notice shall be reported, within thirty (30) days after a termination of a previously filed agreement, to the Commissioner for determination of the type of filing required, if any:

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

- (2) with respect to life insurers, three percent (3%) of the insurer's admitted assets as of the 31st day of December next preceding,
- c. reinsurance agreements or modifications thereto, including:
 - (1) all reinsurance pooling agreements, and
 - (2) agreements in which the reinsurance premium or a change in the insurer's liabilities, or the projected reinsurance premium or a change in the insurer's liabilities in any of the next three (3) years, equals or exceeds five percent (5%) of the insurer's surplus as regards policyholders, as of the 31st day of December next preceding, including those agreements which may require as consideration the transfer of assets from an insurer to a nonaffiliate, if an agreement or understanding exists between the insurer and nonaffiliate that any portion of the assets will be transferred to one or more affiliates of the insurer,
- d. all management agreements, service contracts, tax allocation agreements, guarantees and all cost-sharing arrangements,
- e. guarantees when made by a domestic insurer; provided, however, that a guarantee which is quantifiable as to amount is not subject to the notice requirements of this paragraph unless it exceeds the lesser of one-half of one percent (.5%) of the insurer's admitted assets or ten percent (10%) of surplus as regards policyholders as of the 31st day of December next preceding. Further, all guarantees which are not quantifiable as to amount are subject to the notice requirements of this paragraph,
- f. direct or indirect acquisitions or investments in a person that controls the insurer or in an affiliate of the insurer in an amount which, together with its present holdings in such investments, exceeds two and one-half percent (2.5%) of the insurer's surplus to policyholders. Direct or indirect acquisitions or investments in subsidiaries acquired pursuant to Section 1632 of this title (or authorized under any other section of this title), or in nonsubsidiary insurance affiliates that are subject to the provisions of this act, are exempt from this requirement, and

- g. any material transactions, specified by regulation, which the Commissioner determines may adversely affect the interests of the insurer's policyholders.

Nothing in this paragraph shall be deemed to authorize or permit any transactions which, in the case of an insurer not a member of the same insurance holding company system, would be otherwise contrary to law.

3. A domestic insurer may not enter into transactions which are part of a plan or series of like transactions with persons within the insurance holding company system if the purpose of those separate transactions is to avoid the statutory threshold amount and thus avoid the review that would occur otherwise. If the Commissioner determines that separate transactions were entered into over any twelve-month period for that purpose, the Commissioner may exercise his or her authority under Section 1641 of this title.

4. The Commissioner, in reviewing transactions pursuant to paragraph 2 of this subsection, shall consider whether the transactions comply with the standards set forth in paragraph 1 of this subsection and whether they may adversely affect the interests of policyholders.

5. The Commissioner shall be notified within thirty (30) days of any investment of the domestic insurer in any one corporation if the total investment in the corporation by the insurance holding company system exceeds ten percent (10%) of the corporation's voting securities.

- 6. a. Any affiliate that is party to an agreement or contract with a domestic insurer that is subject to subparagraph d of paragraph 2 of this subsection shall be subject to the jurisdiction of any supervision, seizure, conservatorship, or receivership proceedings against the insurer and to the authority of any supervisor, conservator, rehabilitator, or liquidator for the insurer appointed pursuant to Article 18 or 19 of this title regarding rehabilitation and liquidation of insurers for the purpose of interpreting, enforcing, and overseeing the affiliate's obligations under the agreement or contract to perform services for the insurer that are:
 - (1) an integral part of the insurer's operations, including, but not limited to, management, administrative, accounting, data processing, marketing, underwriting, claims handling, investment, or any other similar functions, or
 - (2) essential to the insurer's ability to fulfill its obligations under insurance policies.
- b. The Commissioner may require that an agreement or contract pursuant to subparagraph d of paragraph 2 of

this subsection for the provision of services described in divisions (1) and (2) of subparagraph a of this paragraph specify the affiliate consents to the jurisdiction as set forth in this paragraph.

B. No domestic insurer shall pay any extraordinary dividend or make any other extraordinary distribution to its shareholders until thirty (30) days after the Commissioner has received notice of the declaration thereof and has not within that period disapproved the payment, or until the Commissioner has approved the payment within the thirty-day period. For purposes of this section, an extraordinary dividend or distribution includes any dividend or distribution of cash or other property whose fair market value together with that of other dividends or distributions made within the preceding twelve (12) months exceeds the greater of:

1. Ten percent (10%) of the insurer's surplus as regards policyholders as of the 31st day of December next preceding; or

2. The net gain from operations of the insurer, if the insurer is a life insurer, or the net income, if the insurer is not a life insurer, not including realized capital gains, for the twelve-month period ending the 31st day of December next preceding, but shall not include pro rata distributions of any class of the insurer's own securities.

In determining whether a dividend or distribution is extraordinary, an insurer other than a life insurer may carry forward net income from the previous two (2) calendar years that has not already been paid out as dividends. This carry-forward shall be computed by taking the net income from the second and third preceding calendar years, not including realized capital gains, less dividends paid in the second and immediate preceding calendar years.

Notwithstanding any other provision of law, an insurer may declare an extraordinary dividend or distribution which is conditional upon the Commissioner's approval, and the declaration shall confer no rights upon shareholders until (1) the Commissioner has approved the payment of the dividend or distribution or (2) the Commissioner has not disapproved payment within the thirty-day period.

C. 1. Notwithstanding the control of a domestic insurer by any person, the officers and directors of the insurer shall not thereby be relieved of any obligation or liability to which they would otherwise be subject by law, and the insurer shall be managed so as to assure its separate operating identity consistent with this act.

2. Nothing in this section shall preclude a domestic insurer from having or sharing a common management or cooperative or joint use of personnel, property or services with one or more other persons under arrangements meeting the standards of paragraph 1 of subsection A of this section.

3. Not less than one-third (1/3) of the directors of a domestic insurer, and not less than one-third (1/3) of the members of each committee of the board of directors of any domestic insurer, shall be persons who are not officers or employees of the insurer or of any entity controlling, controlled by, or under common control with the insurer and who are not beneficial owners of a controlling interest in the voting stock of the insurer or entity. At least one such person must be included in any quorum for the transaction of business at any meeting of the board of directors or any committee thereof.

4. The board of directors of a domestic insurer shall establish one or more committees comprised solely of directors who are not officers or employees of the insurer or of any entity controlling, controlled by, or under common control with the insurer and who are not beneficial owners of a controlling interest in the voting stock of the insurer or any such entity. The committee or committees shall have responsibility for nominating candidates for director for election by shareholders or policyholders, evaluating the performance of officers deemed to be principal officers of the insurer and recommending to the board of directors the selection and compensation of the principal officers.

5. The provisions of paragraphs 3 and 4 of this subsection shall not apply to a domestic insurer if the person controlling the insurer, such as an insurer, a mutual insurance holding company, or a publicly held corporation, has a board of directors and committees thereof that meet the requirements of paragraphs 3 and 4 of this subsection with respect to such controlling entity.

6. An insurer may make application to the Commissioner for a waiver from the requirements of this subsection, if the insurer's annual direct written and assumed premium, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, is less than Three Hundred Million Dollars (\$300,000,000.00). An insurer may also make application to the Commissioner for a waiver from the requirements of this subsection based upon unique circumstances. The Commissioner may consider various factors including, but not limited to, the type of business entity, volume of business written, availability of qualified board members, or the ownership or organizational structure of the entity.

D. For purposes of this act, in determining whether an insurer's surplus as regards policyholders is reasonable in relation to the insurer's outstanding liabilities and adequate to meet its financial needs, the following factors, among others, shall be considered:

1. The size of the insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force and other appropriate criteria;

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

3. The number and size of risks insured in each line of business;

4. The extent of the geographical dispersion of the insurer's insured risks;

5. The nature and extent of the insurer's reinsurance program;

6. The quality, diversification and liquidity of the insurer's investment portfolio;

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

8. The surplus as regards policyholders maintained by other comparable insurers;

9. The adequacy of the insurer's reserves; and

10. The quality and liquidity of investments in affiliates.

The Commissioner may treat any such investment as a disallowed asset for purposes of determining the adequacy of surplus as regards policyholders whenever in the judgment of the Commissioner the investment so warrants.

Added by Laws 2017, c. 350, § 6, emerg. eff. May 31, 2017. Amended by Laws 2022, c. 119, § 1, eff. Nov. 1, 2022.

§36-1637. Examination of registered insurers.

A. Subject to the limitation contained in this section and in addition to the powers which the Commissioner has under Sections 309.1 through 309.7 of Title 36 of the Oklahoma Statutes relating to the examination of insurers, the Commissioner shall have the power to examine any insurer registered under Section 5 of this act and its affiliates to ascertain the financial condition of the insurer, including the enterprise risk to the insurer by the ultimate controlling party, or by any entity or combination of entities within the insurance holding company system, or by the insurance holding company system on a consolidated basis.

B. 1. The Commissioner may order any insurer registered under Section 5 of this act to produce such records, books or other information papers in the possession of the insurer or its affiliates as are reasonably necessary to determine compliance with Title 36 of the Oklahoma Statutes.

2. To determine compliance with Title 36 of the Oklahoma Statutes, the Commissioner may order any insurer registered under Section 5 of this act to produce information not in the possession of the insurer if the insurer can obtain access to such information pursuant to contractual relationships, statutory obligations or other method. In the event the insurer cannot obtain the information requested by the Commissioner, the insurer shall provide the Commissioner a detailed explanation of the reason that the insurer cannot obtain the information and the identity of the holder

of the information. Whenever it appears to the Commissioner that the detailed explanation is without merit, the Commissioner may require, after notice and hearing, the insurer to pay a penalty of Five Hundred Dollars (\$500.00) for each day's delay, or may suspend or revoke the insurer's license.

C. The Commissioner may retain at the registered insurer's expense such attorneys, actuaries, accountants and other experts not otherwise a part of the Commissioner's staff as shall be reasonably necessary to assist in the conduct of the examination under subsection A of this section. Any persons so retained shall be under the direction and control of the Commissioner and shall act in a purely advisory capacity.

D. Each registered insurer producing for examination records, books and papers pursuant to subsection A of this section shall be liable for and shall pay the expense of examination in accordance with Section 309.6 of Title 36 of the Oklahoma Statutes.

E. In the event the insurer fails to comply with an order, the Commissioner shall have the power to examine the affiliates to obtain the information. The Commissioner shall also have the power to issue subpoenas, to administer oaths, and to examine under oath any person for purposes of determining compliance with this section. Upon the failure or refusal of any person to obey a subpoena, the Commissioner may petition a court of competent jurisdiction, and upon proper showing, the court may enter an order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order shall be punishable as contempt of court. Every person shall be obliged to attend as a witness at the place specified in the subpoena, when subpoenaed, anywhere within the state. He or she shall be entitled to the fees and mileage, if claimed, as provided for witness fees pursuant to Section 81 of Title 28 of the Oklahoma Statutes, and such expense shall be itemized and charged against, and be paid by, the company being examined.

Added by Laws 2017, c. 350, § 7, emerg. eff. May 31, 2017.

§36-1638. Commissioner power to participate in supervisory colleges.

A. With respect to any insurer registered under Section 5 of this act, and in accordance with subsection C of this section, the Commissioner shall also have the power to participate in a supervisory college for any domestic insurer that is part of an insurance holding company system with international operations in order to determine compliance by the insurer with Title 36 of the Oklahoma Statutes. The powers of the Commissioner with respect to supervisory colleges include, but are not limited to, the following:

1. Initiating the establishment of a supervisory college;

2. Clarifying the membership and participation of other supervisors in the supervisory college;

3. Clarifying the functions of the supervisory college and the role of other regulators, including the establishment of a group-wide supervisor;

4. Coordinating the ongoing activities of the supervisory college, including planning meetings, supervisory activities, and processes for information sharing; and

5. Establishing a crisis management plan.

B. Each registered insurer subject to this section shall be liable for and shall pay the reasonable expenses of the Commissioner's participation in a supervisory college in accordance with subsection C of this section, including reasonable travel expenses. For purposes of this section, a supervisory college may be convened as either a temporary or permanent forum for communication and cooperation between the regulators charged with the supervision of the insurer or its affiliates, and the Commissioner may establish a regular assessment to the insurer for the payment of these expenses.

C. In order to assess the business strategy, financial position, legal and regulatory position, risk exposure, risk management and governance processes, and as part of the examination of individual insurers in accordance with Section 7 of this act, the Commissioner may participate in a supervisory college with other regulators charged with supervision of the insurer or its affiliates, including other state, federal and international regulatory agencies. The Commissioner may enter into agreements in accordance with subsection C of Section 10 of this act providing the basis for cooperation between the Commissioner and the other regulatory agencies, and the activities of the supervisory college. Nothing in this section shall delegate to the supervisory college the authority of the Commissioner to regulate or supervise the insurer or its affiliates within its jurisdiction.

Added by Laws 2017, c. 350, § 8, emerg. eff. May 31, 2017.

§36-1639. Group-wide supervisor for any internationally active insurance group.

A. The Commissioner is authorized to act as the group-wide supervisor for any internationally active insurance group in accordance with the provisions of this section. However, the Commissioner may otherwise acknowledge another regulatory official as the group-wide supervisor where the internationally active insurance group:

1. Does not have substantial insurance operations in the United States;

2. Has substantial insurance operations in the United States, but not in this state; or

3. Has substantial insurance operations in the United States and this state, but the Commissioner has determined pursuant to the factors set forth in subsections B and F of this section that the other regulatory official is the appropriate group-wide supervisor. An insurance holding company system that does not otherwise qualify as an internationally active insurance group may request that the Commissioner make a determination or acknowledgment as to a group-wide supervisor pursuant to this section.

B. In cooperation with other state, federal and international regulatory agencies, the Commissioner will identify a single group-wide supervisor for an internationally active insurance group. The Commissioner may determine that the Commissioner is the appropriate group-wide supervisor for an internationally active insurance group that conducts substantial insurance operations concentrated in this state. However, the Commissioner may acknowledge that a regulatory official from another jurisdiction is the appropriate group-wide supervisor for the internationally active insurance group. The Commissioner shall consider the following factors when making a determination or acknowledgment under this subsection:

1. The place of domicile of the insurers within the internationally active insurance group that hold the largest share of the group's written premiums, assets or liabilities;

2. The place of domicile of the top-tiered insurer or insurers in the insurance holding company system of the internationally active insurance group;

3. The location of the executive offices or largest operational offices of the internationally active insurance group;

4. Whether another regulatory official is acting or is seeking to act as the group-wide supervisor under a regulatory system that the Commissioner determines to be:

a. substantially similar to the system of regulation provided under the laws of this state, or

b. otherwise sufficient in terms of providing for group-wide supervision, enterprise risk analysis, and cooperation with other regulatory officials; and

5. Whether another regulatory official acting or seeking to act as the group-wide supervisor provides the Commissioner with reasonably reciprocal recognition and cooperation. However, a Commissioner identified under this section as the group-wide supervisor may determine that it is appropriate to acknowledge another supervisor to serve as the group-wide supervisor. The acknowledgment of the group-wide supervisor shall be made after consideration of the factors listed in this paragraph and paragraphs 1 through 4 of this subsection, and shall be made in cooperation with and subject to the acknowledgment of other regulatory officials involved with supervision of members of the internationally active

insurance group, and in consultation with the internationally active insurance group.

C. Notwithstanding any other provision of law, when another regulatory official is acting as the group-wide supervisor of an internationally active insurance group, the Commissioner shall acknowledge that regulatory official as the group-wide supervisor. However, in the event of a material change in the internationally active insurance group that results in:

1. The internationally active insurance group's insurers domiciled in this state holding the largest share of the group's premiums, assets or liabilities; or

2. This state being the place of domicile of the top-tiered insurer or insurers in the insurance holding company system of the internationally active insurance group, the Commissioner shall make a determination or acknowledgment as to the appropriate group-wide supervisor for such an internationally active insurance group pursuant to subsection B of this section.

D. Pursuant to Section 7 of this act, the Commissioner is authorized to collect from any insurer registered pursuant to Section 5 of this act all information necessary to determine whether the Commissioner may act as the group-wide supervisor of an internationally active insurance group or if the Commissioner may acknowledge another regulatory official to act as the group-wide supervisor. Prior to issuing a determination that an internationally active insurance group is subject to group-wide supervision by the Commissioner, the Commissioner shall notify the insurer registered pursuant to Section 5 and the ultimate controlling person within the internationally active insurance group. The internationally active insurance group shall have not less than thirty (30) days to provide the Commissioner with additional information pertinent to the pending determination. The Commissioner shall publish on its Internet website the identity of internationally active insurance groups that the Commissioner has determined are subject to group-wide supervision by the Commissioner.

E. If the Commissioner is the group-wide supervisor for an internationally active insurance group, the Commissioner is authorized to engage in any of the following group-wide supervision activities:

1. Assess the enterprise risks within the internationally active insurance group to ensure that:

- a. the material financial condition and liquidity risks to the members of the internationally active insurance group that are engaged in the business of insurance are identified by management, and
- b. reasonable and effective mitigation measures are in place;

2. Request, from any member of an internationally active insurance group subject to the Commissioner's supervision, information necessary and appropriate to assess enterprise risk, including, but not limited to, information about the members of the internationally active insurance group regarding:

- a. governance, risk assessment and management,
- b. capital adequacy, and
- c. material intercompany transactions;

3. Coordinate and, through the authority of the regulatory officials of the jurisdictions where members of the internationally active insurance group are domiciled, compel development and implementation of reasonable measures designed to ensure that the internationally active insurance group is able to timely recognize and mitigate enterprise risks to members of such internationally active insurance group that are engaged in the business of insurance;

4. Communicate with other state, federal and international regulatory agencies for members within the internationally active insurance group and share relevant information subject to the confidentiality provisions of Section 10 of this act, through supervisory colleges as set forth in Section 8 of this act or otherwise;

5. Enter into agreements with or obtain documentation from any insurer registered under Section 5 of this act, any member of the internationally active insurance group, and any other state, federal and international regulatory agencies for members of the internationally active insurance group, providing the basis for or otherwise clarifying the Commissioner's role as group-wide supervisor, including provisions for resolving disputes with other regulatory officials. Such agreements or documentation shall not serve as evidence in any proceeding that any insurer or person within an insurance holding company system not domiciled or incorporated in this state is doing business in this state or is otherwise subject to jurisdiction in this state; and

6. Other group-wide supervision activities, consistent with the authorities and purposes enumerated above, as considered necessary by the Commissioner.

F. If the Commissioner acknowledges that another regulatory official from a jurisdiction that is not accredited by the National Association of Insurance Commissioners is the group-wide supervisor, the Commissioner is authorized to reasonably cooperate, through supervisory colleges or otherwise, with group-wide supervision undertaken by the group-wide supervisor, provided that:

1. The Commissioner's cooperation is in compliance with the laws of this state; and

2. The regulatory official acknowledged as the group-wide supervisor also recognizes and cooperates with the Commissioner's

activities as a group-wide supervisor for other internationally active insurance groups where applicable. Where such recognition and cooperation is not reasonably reciprocal, the Commissioner is authorized to refuse recognition and cooperation.

G. The Commissioner is authorized to enter into agreements with or obtain documentation from any insurer registered under Section 5 of this act, any affiliate of the insurer, and other state, federal and international regulatory agencies for members of the internationally active insurance group, that provide the basis for or otherwise clarify a regulatory official's role as group-wide supervisor.

H. The Commissioner may promulgate regulations necessary for the administration of this section.

I. A registered insurer subject to this section shall be liable for and shall pay the reasonable expenses of the Commissioner's participation in the administration of this section, including the engagement of attorneys, actuaries and any other professionals and all reasonable travel expenses.

Added by Laws 2017, c. 350, § 9, emerg. eff. May 31, 2017.

§36-1640. Confidentiality of documents and other information.

A. Documents, materials or other information in the possession or control of the Insurance Department that are obtained by or disclosed to the Commissioner or any other person in the course of an examination or investigation made pursuant to Section 7 of this act and all information reported or provided to the Insurance Department pursuant to paragraphs 12 and 13 of subsection B of Section 3 of this act, Section 5 of this act, Section 6 of this act and Section 11 of this act shall be confidential by law and privileged, shall not be subject to open records, or freedom of information, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the Commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the Commissioner's official duties. The Commissioner shall not otherwise make the documents, materials or other information public without the prior written consent of the insurer to which it pertains unless the Commissioner, after giving the insurer and its affiliates who would be affected thereby notice and opportunity to be heard, determines that the interest of policyholders, shareholders or the public will be served by the publication thereof, in which event the Commissioner may publish all or any part in such manner as may be deemed appropriate.

B. Neither the Commissioner nor any person who received documents, materials or other information while acting under the authority of the Commissioner or with whom such documents, materials

or other information are shared pursuant to this act shall be permitted or required to testify in any private civil action concerning any confidential documents, materials or information subject to subsection A of this section.

C. In order to assist in the performance of the Commissioner's duties, the Commissioner:

1. May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to subsection A of this section, with other state, federal and international regulatory agencies, with the National Association of Insurance Commissioners (NAIC) and its affiliates and subsidiaries, and with state, federal and international law enforcement authorities, including members of any supervisory college described in Section 8 of this act, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the document, material or other information, and has verified in writing the legal authority to maintain confidentiality;

2. Notwithstanding paragraph 1 of this subsection, may only share confidential and privileged documents, material or information reported pursuant to subsection L of Section 5 of this act with Commissioners of states having statutes or regulations substantially similar to subsection A of this section and who have agreed in writing not to disclose such information;

3. May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information from the NAIC and its affiliates and subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

4. Shall enter into written agreements with the NAIC governing sharing and use of information provided pursuant to this act consistent with this subsection that shall:

- a. specify procedures and protocols regarding the confidentiality and security of information shared with the NAIC and its affiliates and subsidiaries pursuant to this act, including procedures and protocols for sharing by the NAIC with other state, federal or international regulators,
- b. specify that ownership of information shared with the NAIC and its affiliates and subsidiaries pursuant to this act remains with the Commissioner and the NAIC's use of the information is subject to the direction of the Commissioner,

- c. require prompt notice to be given to an insurer whose confidential information in the possession of the NAIC pursuant to this act is subject to a request or subpoena to the NAIC for disclosure or production, and
- d. require the NAIC and its affiliates and subsidiaries to consent to intervention by an insurer in any judicial or administrative action in which the NAIC and its affiliates and subsidiaries may be required to disclose confidential information about the insurer shared with the NAIC and its affiliates and subsidiaries pursuant to this act.

D. The sharing of information by the Commissioner pursuant to this act shall not constitute a delegation of regulatory authority or rulemaking, and the Commissioner is solely responsible for the administration, execution and enforcement of the provisions of this act.

E. No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the Commissioner under this section or as a result of sharing as authorized in subsection C of this section.

F. Documents, materials or other information in the possession or control of the NAIC pursuant to this act shall be confidential by law and privileged, shall not be subject to open records or freedom of information, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.

Added by Laws 2017, c. 350, § 10, emerg. eff. May 31, 2017.

§36-1641. Authority to issue rules, regulations, and orders.

The Commissioner may issue such rules, regulations and orders as shall be necessary to carry out the provisions of Section 1631 et seq. of this title.

Added by Laws 2017, c. 350, § 11, emerg. eff. May 31, 2017. Amended by Laws 2024, c. 345, § 14, eff. Nov. 1, 2024.

§36-1642. Injunctions - Voting of securities prohibited - Sequestration of voting securities.

A. Whenever it appears to the Commissioner that any insurer or any director, officer, employee or agent thereof has committed or is about to commit a violation of this act or of any rule, regulation or order issued by the Commissioner hereunder, the Commissioner may apply to the district court for the county in which the principal office of the insurer is located or if the insurer has no office in this state then to the district court for Oklahoma County for an order enjoining the insurer or director, officer, employee or agent thereof from violating or continuing to violate this act or any

rule, regulation or order, and for such other equitable relief as the nature of the case and the interest of the insurer's policyholders, creditors and shareholders or the public may require.

B. No security which is the subject of any agreement or arrangement regarding acquisition, or which is acquired or to be acquired, in contravention of the provisions of this act or of any rule, regulation or order issued by the Commissioner hereunder may be voted at any shareholder's meeting, or may be counted for quorum purposes, and any action of shareholders requiring the affirmative vote of a percentage of shares may be taken as though the securities were not issued and outstanding; but no action taken at any such meeting shall be invalidated by the voting of the securities, unless the action would materially affect control of the insurer or unless the courts of this state have so ordered. If an insurer or the Commissioner has reason to believe that any security of the insurer has been or is about to be acquired in contravention of the provisions of this act or of any rule, regulation or order issued by the Commissioner hereunder, the insurer or the Commissioner may apply to the district court for the county in which the insurer has its principal place of business to enjoin any offer, request, invitation, agreement or acquisition made in contravention of Section 3 of this act or any rule, regulation or order issued by the Commissioner thereunder to enjoin the voting of any security so acquired, to void any vote of the security already cast at any meeting of shareholders and for such other equitable relief as the nature of the case and the interest of the insurer's policyholders, creditor and shareholders or the public may require.

C. In any case where a person has acquired or is proposing to acquire any voting securities in violation of this act or any rule, regulation or order issued by the Commissioner hereunder, the district court for Oklahoma County or the district court for the county in which the insurer has its principal place of business may, on such notice as the court deems appropriate, upon the application of the insurer or the Commissioner, seize or sequester any voting securities of the insurer owned directly or indirectly by the person, and issue such order as may be appropriate to effectuate the provisions of this act. For the purposes of this act the situs of the ownership of the securities of domestic insurers shall be deemed to be in this state.

Added by Laws 2017, c. 350, § 12, emerg. eff. May 31, 2017.

§36-1643. Failure to file - Penalties - Unlawful transactions or investments - Willful violations - False statements.

A. Any insurer failing, without just cause, to file any registration statement as required in this act shall be required, after notice and hearing, to pay a penalty of Five Hundred Dollars (\$500.00) for each day's delay, to be recovered by the Insurance

Commissioner and the penalty so recovered shall be paid as provided in Section 307.5 of Title 36 of the Oklahoma Statutes. The maximum penalty under this section is One Hundred Thousand Dollars (\$100,000.00). The Commissioner may reduce the penalty if the insurer demonstrates to the Commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.

B. Every director or officer of an insurance holding company system who knowingly violates, participates in or assents to, or who knowingly shall permit any of the officers or agents of the insurer to engage in, transactions or make investments which have not been properly reported or submitted pursuant to subsection A of Section 5 of this act, paragraph 2 of subsection A of Section 6 of this act or subsection B of Section 6 of this act, or which violate this act, shall pay, in their individual capacity, a civil forfeiture of not more than Twenty-five Thousand Dollars (\$25,000.00) per violation, after notice and hearing before the Commissioner. In determining the amount of the civil forfeiture, the Commissioner shall take into account the appropriateness of the forfeiture with respect to the gravity of the violation, the history of previous violations, and such other matters as justice may require.

C. Whenever it appears to the Commissioner that any insurer subject to this act or any director, officer, employee or agent thereof has engaged in any transaction or entered into a contract which is subject to Section 6 of this act and which would not have been approved had the approval been requested, the Commissioner may order the insurer to cease and desist immediately any further activity under that transaction or contract. After notice and hearing the Commissioner may also order the insurer to void any contracts and restore the status quo if the action is in the best interest of the policyholders, creditors or the public.

D. Whenever it appears to the Commissioner that any insurer or any director, officer, employee or agent thereof has committed a willful violation of this act, the Commissioner may submit such information to the district attorney for Oklahoma County for appropriate action against the insurer or the responsible director, officer, employee or agent thereof. Any insurer which willfully violates this act may be fined not more than One Hundred Thousand Dollars (\$100,000.00). Any individual who willfully violates this act may be fined in his or her individual capacity not more than Fifty Thousand Dollars (\$50,000.00) or be imprisoned for not more than one (1) to three (3) years or both.

E. Any officer, director or employee of an insurance holding company system who willfully and knowingly subscribes to or makes or causes to be made any false statements or false reports or false filings with the intent to deceive the Commissioner in the performance of his or her duties under this act, upon conviction shall be imprisoned for not more than five (5) years or fined One

Hundred Fifty Thousand Dollars (\$150,000.00) or both. Any fines imposed shall be paid by the officer, director or employee in his or her individual capacity.

F. Whenever it appears to the Commissioner that any person has committed a violation of Section 3 of this act which prevents the full understanding of the enterprise risk to the insurer by affiliates or by the insurance holding company system, the violation may serve as an independent basis for disapproving dividends or distributions and for placing the insurer under an order of supervision in accordance with Article 18 of Title 36 of the Oklahoma Statutes.

Added by Laws 2017, c. 350, § 13, emerg. eff. May 31, 2017.

§36-1644. Violations threatening insolvency - Possession taken by Commissioner.

Whenever it appears to the Commissioner that any person has committed a violation of this act which so impairs the financial condition of a domestic insurer as to threaten insolvency or make the further transaction of business by it hazardous to its policyholders, creditors, shareholders or the public, then the Commissioner may proceed as provided in Articles 18 and 19 of Title 36 of the Oklahoma Statutes to take possession of the property of the domestic insurer and to conduct its business.

Added by Laws 2017, c. 350, § 14, emerg. eff. May 31, 2017.

§36-1645. Recovery of distributions by receiver - Liability.

A. If an order for liquidation or rehabilitation of a domestic insurer has been entered, the receiver appointed under the order shall have a right to recover on behalf of the insurer:

1. From any parent corporation or holding company or person or affiliate who otherwise controlled the insurer, the amount of distributions (other than distributions of shares of the same class of stock) paid by the insurer on its capital stock; or

2. Any payment in the form of a bonus, termination settlement or extraordinary lump-sum salary adjustment made by the insurer or its subsidiary, to a director, officer or employee, where the distribution or payment pursuant to paragraph 1 or 2 of this subsection is made at any time during the one (1) year preceding the petition for liquidation, conservation or rehabilitation, as the case may be, subject to the limitations of subsections B, C and D of this section.

B. No distribution shall be recoverable if the parent or affiliate shows that when paid the distribution was lawful and reasonable, and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

C. Any person who was a parent corporation or holding company or a person who otherwise controlled the insurer or affiliate at the time the distributions were paid shall be liable up to the amount of distributions or payments under subsection A of this section which the person received. Any person who otherwise controlled the insurer at the time the distributions were declared shall be liable up to the amount of distributions that would have been received if they had been paid immediately. If two or more persons are liable with respect to the same distributions, they shall be jointly and severally liable.

D. The maximum amount recoverable under this section shall be the amount needed in excess of all other available assets of the impaired or insolvent insurer to pay the contractual obligations of the impaired or insolvent insurer and to reimburse any guaranty funds.

E. To the extent that any person liable under subsection C of this section is insolvent or otherwise fails to pay claims due from it, its parent corporation or holding company or person who otherwise controlled it at the time the distribution was paid shall be jointly and severally liable for any resulting deficiency in the amount recovered from the parent corporation or holding company or person who otherwise controlled it.

Added by Laws 2017, c. 350, § 15, emerg. eff. May 31, 2017.

§36-1646. Authority to suspend, revoke or refuse to renew license or authority to do business.

Whenever it appears to the Commissioner that any person has committed a violation of this act which makes the continued operation of an insurer contrary to the interests of policyholders or the public, the Commissioner may, after giving notice and an opportunity to be heard, suspend, revoke or refuse to renew the insurer's license or authority to do business in this state for such period as the Commissioner finds is required for the protection of policyholders or the public. Any such determination shall be accompanied by specific findings of fact and conclusions of law.

Added by Laws 2017, c. 350, § 16, emerg. eff. May 31, 2017.

§36-1647. Appeal to district court by aggrieved persons.

A. Any person aggrieved by any act, determination, rule, regulation or order or any other action of the Commissioner pursuant to this act may appeal to the district court for Oklahoma County. The court shall conduct its review without a jury and by trial de novo, except that if all parties, including the Commissioner, so stipulate, the review shall be confined to the record. Portions of the record may be introduced by stipulation into evidence in a trial de novo as to those parties so stipulating.

B. The filing of an appeal pursuant to this section shall stay the application of any rule, regulation, order or other action of the Commissioner to the appealing party unless the court, after giving the party notice and an opportunity to be heard, determines that a stay would be detrimental to the interest of policyholders, shareholders, creditors or the public.

C. Any person aggrieved by any failure of the Commissioner to act or make a determination required by this act may petition the district court for Oklahoma County for a writ in the nature of a mandamus or a peremptory mandamus directing the Commissioner to act or make a determination.

Added by Laws 2017, c. 350, § 17, emerg. eff. May 31, 2017.

§36-1648. Powers, remedies, procedures and penalties as additional.

The powers, remedies, procedures and penalties provided in this act shall be in addition to, and not in limitation of, any other powers, remedies, procedures and penalties provided by law.

Added by Laws 2017, c. 350, § 18, emerg. eff. May 31, 2017.

§36-1651. Repealed by Laws 2017, c. 350, § 19, emerg. eff. May 31, 2017.

§36-1652. Repealed by Laws 2017, c. 350, § 19, emerg. eff. May 31, 2017.

§36-1653. Repealed by Laws 2017, c. 350, § 19, emerg. eff. May 31, 2017.

§36-1654. Repealed by Laws 2017, c. 350, § 19, emerg. eff. May 31, 2017.

§36-1655. Repealed by Laws 2017, c. 350, § 19, emerg. eff. May 31, 2017.

§36-1656. Repealed by Laws 2017, c. 350, § 19, emerg. eff. May 31, 2017.

§36-1656.1. Repealed by Laws 2017, c. 350, § 19, emerg. eff. May 31, 2017.

§36-1657. Repealed by Laws 2013, c. 269, § 26, eff. Nov. 1, 2013.

§36-1657.1. Repealed by Laws 2017, c. 350, § 19, emerg. eff. May 31, 2017.

§36-1658. Repealed by Laws 1992, c. 178, § 41, eff. Sept. 1, 1992.

§36-1658.1. Repealed by Laws 2017, c. 350, § 19, emerg. eff. May 31, 2017.

§36-1658.2. Repealed by Laws 2017, c. 350, § 19, emerg. eff. May 31, 2017.

§36-1659. Repealed by Laws 1992, c. 178, § 41, eff. Sept. 1, 1992.

§36-1659.1. Repealed by Laws 2017, c. 350, § 19, emerg. eff. May 31, 2017.

§36-1659.2. Repealed by Laws 2017, c. 350, § 19, emerg. eff. May 31, 2017.

§36-1659.3. Repealed by Laws 1997, c. 418, § 125, eff. Nov. 1, 1997.

§36-1660. Repealed by Laws 2017, c. 350, § 19, emerg. eff. May 31, 2017.

§36-1661. Repealed by Laws 2017, c. 350, § 19, emerg. eff. May 31, 2017.

§36-1662. Repealed by Laws 2017, c. 350, § 19, emerg. eff. May 31, 2017.

§36-1671. Short title.

Sections 13 through 19 of this act may be cited as the "Business Transacted with Producer Controlled Insurer Act".

Added by Laws 1992, c. 178, § 13, eff. Sept. 1, 1992.

§36-1672. Definitions.

As used in the Business Transacted with Producer Controlled Insurer Act:

1. "Accredited State" means a state in which the insurance department or regulatory agency has qualified as meeting the minimum financial regulatory standards promulgated and established from time to time by the National Association of Insurance Commissioners (NAIC);

2. "Control" or "Controlled" has the meaning ascribed in subsection (c) of Section 1651 of Title 36 of the Oklahoma Statutes;

3. "Controlled Insurer" means a licensed insurer which is controlled, directly or indirectly, by a producer;

4. "Controlling Producer" means a producer who, directly or indirectly, controls an insurer;

5. "Licensed Insurer" or "Insurer" means any person, firm, association or corporation duly licensed to transact a property/casualty insurance business in this state. The following, inter alia, are not licensed insurers for the purposes of this act:

- a. all risk retention groups as defined in the Superfund Amendments Reauthorization Act of 1986, Pub. L. No. 99-499, 100 Stat. 1613 (1986) and the Risk Retention Act, 15 U.S.C. Section 3901 et seq. (1982 & Supp. 1986) and Section 6451 et seq. of Title 36 of the Oklahoma Statutes,
- b. all residual market pools and joint underwriting authorities or associations, and
- c. all captive insurers. For the purposes of the Business Transacted with Producer Controlled Insurer Act, captive insurers are insurance companies owned by another organization whose exclusive purpose is to insure risks of the parent organization and affiliated companies or, in the case of groups and associations, insurance organizations owned by the insureds whose exclusive purpose is to insure risks to member organizations and/or group members and their affiliates; and

6. "Producer" means an insurance broker or brokers or any other person, firm, association or corporation, when, for any compensation, commission or other thing of value, such person, firm, association or corporation acts or aids in any manner in soliciting, negotiating or procuring the making of any insurance contract on behalf of an insured other than the person, firm, association or corporation.

Added by Laws 1992, c. 178, § 14, eff. Sept. 1, 1992.

§36-1673. Applicability of Act.

The Business Transacted with Producer Controlled Insurer Act shall apply to licensed insurers as defined in Section 14 of this act, either domiciled in this state or domiciled in a state that is not an accredited state having in effect a substantially similar law. All provisions of Article 16A of the Insurance Code, to the extent they are not superseded by this act, shall continue to apply to all parties within holding company systems subject to this act.

Added by Laws 1992, c. 178, § 15, eff. Sept. 1, 1992.

§36-1674. Required contract provisions - Producers and insurers affected - Audit Committees - Reporting requirements.

A. Applicability of section.

1. The provisions of this section shall apply if, in any calendar year, the aggregate amount of gross written premium on business placed with a controlled insurer by a controlling producer

is equal to or greater than five percent (5%) of the admitted assets of the controlled insurer, as reported in the controlled insurers' quarterly statement filed as of September 30 of the prior year.

2. Notwithstanding paragraph 1 of this subsection, the provisions of this section shall not apply if:

a. the controlling producer:

- (1) places insurance only with the controlled insurer, or only with the controlled insurer and a member or members of the controlled insurer's holding company system, or the controlled insurer's parent, affiliate or subsidiary and receives no compensation based upon the amount of premiums written in connection with such insurance, and
- (2) accepts insurance placements only from nonaffiliated subproducers, and not directly from insureds, and

b. the controlled insurer, except for insurance business written through a residual market facility, accepts insurance business only from a controlling producer, a producer controlled by the controlled insurer, or a producer that is a subsidiary of the controlled insurer.

B. Required contract provisions. A controlled insurer shall not accept business from a controlling producer and a controlling producer shall not place business with a controlled insurer unless there is a written contract between the controlling producer and the insurer specifying the responsibilities of each party, which contract has been approved by the board of directors of the insurer and contains the following minimum provisions:

1. The controlled insurer may terminate the contract for cause, upon written notice to the controlling producer. The controlled insurer shall suspend the authority of the controlling producer to write business during the pendency of any dispute regarding the cause for the termination;

2. The controlling producer shall render accounts to the controlled insurer detailing all material transactions, including information necessary to support all commissions, charges and other fees received by, or owing to, the controlling producer;

3. The controlling producer shall remit all funds due under the terms of the contract to the controlled insurer on at least a monthly basis. The due date shall be fixed so that premiums or installments thereof collected shall be remitted no later than ninety (90) days after the effective date of any policy placed with the controlled insurer under this contract;

4. All funds collected for the controlled insurer's account shall be held by the controlling producer in a fiduciary capacity,

in one or more appropriately identified bank accounts in banks that are members of the Federal Reserve System, in accordance with the provisions of the insurance law as applicable. However, funds of a controlling producer not required to be licensed in this state shall be maintained in compliance with the requirements of the controlling producer's domiciliary jurisdiction;

5. The controlling producer shall maintain separately identifiable records of business written for the controlled insurer;

6. The contract shall not be assigned in whole or in part by the controlling producer;

7. The controlled insurer shall provide the controlling producer with its underwriting standards, rules and procedures, manuals setting forth the rates to be charged, and the conditions for the acceptance or rejection of risks. The controlling producer shall adhere to the standards, rules, procedures, rates and conditions. The standards, rules, procedures, rates and conditions shall be the same as those applicable to comparable business placed with the controlled insurer by a producer other than the controlling producer;

8. The rate and terms of the controlling producer's commissions, charges or other fees and the purposes for those charges or fees. The rates of the commissions, charges and other fees shall be no greater than those applicable to comparable business placed with the controlled insurer by producers other than controlling producers. For purposes of this paragraph and paragraph 7 of this subsection, examples of "comparable business" include the same lines of insurance, same kinds of insurance, same kinds of risks, similar policy limits, and similar quality of business;

9. If the contract provides that the controlling producer, on insurance business placed with the insurer, is to be compensated contingent upon the insurer's profits on that business, then such compensation shall not be determined and paid until at least five (5) years after the premiums on liability insurance are earned and at least one (1) year after the premiums are earned on any other insurance. In no event shall the commissions be paid until the adequacy of the controlled insurer's reserves on remaining claims has been independently verified pursuant to subsection D of this section;

10. A limit on the controlling producer's writings in relation to the controlled insurer's surplus and total writings. The insurer may establish a different limit for each line or subline of business. The controlled insurer shall notify the controlling producer when the applicable limit is approached and shall not accept business from the controlling producer if the limit is reached. The controlling producer shall not place business with the controlled insurer if it has been notified by the controlled insurer that the limit has been reached; and

11. The controlling producer may negotiate but shall not bind reinsurance on behalf of the controlled insurer on business the controlling producer places with the controlled insurer, except that the controlling producer may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the controlled insurer contains underwriting guidelines including, for both reinsurance assumed and ceded, a list of reinsurers with which such automatic agreements are in effect, the coverages and amounts of percentages that may be reinsured and commission schedules.

C. Audit Committee. Every controlled insurer shall have an Audit Committee of the Board of Directors composed of independent directors. The Audit Committee shall annually meet with management, the insurer's licensed public accountant or a certified public accountant holding a permit to practice in this state and an independent casualty actuary or other independent loss reserve specialist acceptable to the Commissioner to review the adequacy of the insurer's loss reserves.

D. Reporting requirements.

1. In addition to any other required loss reserve certification, the controlled insurer shall annually, on April 1 of each year, file with the Commissioner an opinion of an independent casualty actuary, or such other independent loss reserve specialist acceptable to the Commissioner, reporting loss ratios for each line of business written and attesting to the adequacy of loss reserves established for losses incurred and outstanding as of year-end, including incurred but not reported losses, on business placed by the producer; and

2. The controlled insurer shall annually report to the Commissioner the amount of commissions paid to the producer, the percentage such amount represents of the net premiums written and comparable amounts and percentage paid to noncontrolling producers for placements of the same kinds of insurance.

Added by Laws 1992, c. 178, § 16, eff. Sept. 1, 1992. Amended by Laws 2015, c. 298, § 10, eff. Nov. 1, 2015.

§36-1675. Notice to insured.

The producer, prior to the effective date of the policy, shall deliver written notice to the prospective insured disclosing the relationship between the producer and the controlled insurer, except that, if the business is placed through a subproducer who is not a controlling producer, the controlling producer shall retain in his records a signed commitment from the subproducer that the subproducer is aware of the relationship between the insurer and the producer and that the subproducer has or will notify the insured.

Added by Laws 1992, c. 178, § 17, eff. Sept. 1, 1992.

§36-1676. Powers of Commissioner or receiver - Civil actions.

A. 1. If the Commissioner believes that the controlling producer or any other person has not materially complied with the Business Transacted with Producer Controlled Insurer Act, or any regulation or order promulgated hereunder, after notice and opportunity to be heard, the Commissioner may order the controlling producer to cease placing business with the controlled insurer; and

2. If it was found that because of such material noncompliance that the controlled insurer or any policyholder thereof has suffered any loss or damage, the Commissioner may maintain a civil action or intervene in an action brought by or on behalf of the insurer or policyholder for recovery of compensatory damages for the benefit of the insurer or policyholder or other appropriate relief.

B. If an order for liquidation or rehabilitation of the controlled insurer has been entered pursuant to Section 1903 of Title 36 of the Oklahoma Statutes, and the receiver appointed under that order believes that the controlling producer or any other person has not materially complied with this act, or any regulation or order promulgated hereunder, and the insurer suffered any loss or damage therefrom, the receiver may maintain a civil action for recovery of damages or other appropriate sanctions for the benefit of the insurer.

C. Nothing contained in this section shall affect the right of the Commissioner to impose any other penalties provided for in the Insurance Code.

D. Nothing contained in this section is intended to or shall in any manner alter or affect the rights of policyholders, claimants, creditors or other third parties.

Added by Laws 1992, c. 178, § 18, eff. Sept. 1, 1992.

§36-1677. Repealed by Laws 1997, c. 418, § 125, eff. Nov. 1, 1997.

§36-1681. Short title - Insurance Business Transfer Act.

This act shall be known and may be cited as the "Insurance Business Transfer Act".

Added by Laws 2018, c. 232, § 1, eff. Nov. 1, 2018.

§36-1682. Purpose of act.

This act is adopted to provide options to address the significant limitations in the current methods available to insurers to transfer or assume blocks of insurance business in an efficient and cost-effective manner that provides needed legal finality for such transfers in order to provide for improved operational and capital efficiency for insurance companies, stimulates the economy by attracting segments of the insurance industry to the state, makes Oklahoma an attractive home jurisdiction for insurance companies, encourages economic growth and increased investment in the financial

services sector and increases the availability of quality insurance industry jobs in Oklahoma. These purposes are accomplished by providing a basis and procedures for the transfer and statutory novation of policies from a transferring insurer to an assuming insurer by way of an Insurance Business Transfer without the affirmative consent of policyholders or reinsureds. The novation is effected by court order. This act establishes the requirements for notice and disclosure and standards and procedures for the approval of the transfer and novation by the Oklahoma Insurance Commissioner and the district court pursuant to an Insurance Business Transfer Plan. This act does not limit or restrict other means of effecting a transfer or novation.

Added by Laws 2018, c. 232, § 2, eff. Nov. 1, 2018. Amended by Laws 2019, c. 381, § 1, eff. Nov. 1, 2019; Laws 2024, c. 195, § 8, eff. Nov. 1, 2024.

§36-1683. Definitions.

1. "Affiliate" has the meaning ascribed to such term in Section 1631 of this title.

2. "Applicant" means an assuming insurer, a transferring insurer, or a reinsurer applying to the Commissioner for approval of an Insurance Business Transfer Plan pursuant to this act.

3. "Assuming insurer" means an insurer domiciled in this state that assumes or seeks to assume policies from a transferring insurer pursuant to this act. An assuming insurer may be a company established pursuant to the Oklahoma Captive Insurance Company Act.

4. "Court" means the district court of a county in Oklahoma with a population of more than two hundred fifty thousand (250,000).

5. "Department" means the Insurance Department.

6. "Commissioner" means the Insurance Commissioner.

7. "Implementation order" means an order issued by the court under Section 1686 of this title.

8. "Independent expert" means a person who shall assist the Commissioner and the court in connection with their review of a proposed transaction. The Commissioner shall select an independent expert from a list of at least two nominees submitted jointly by the transferring insurer and the assuming insurer; provided, however, if the Commissioner, in his or her sole discretion, rejects the nominees submitted jointly by the transferring insurer and the assuming insurer, the Commissioner may appoint another person to serve as an independent expert. An independent expert selected under this subsection shall meet all of the following criteria:

- a. hold no financial interest in either the assuming insurer or the transferring insurer,
- b. not be employed by, or act as an officer, director, consultant, or independent contractor for either the

assuming insurer or the transferring insurer within the previous twelve (12) months,

- c. not be simultaneously appointed by the Commissioner to assist in any capacity in any proceeding initiated pursuant to Article 18 or Article 19 of this title,
- d. receives or is promised no compensation in connection with the Insurance Business Transfer for which he or she is selected to serve as an independent expert; provided, however, a fee may be approved by the Commissioner that is not contingent upon the approval or consummation of an Insurance Business Transfer Plan, and
- e. provides proof of insurance covering the services provided as an independent expert, to be approved by the Commissioner.

9. "Insurance Business Transfer" means a transfer and novation in accordance with this act. Insurance Business Transfers will transfer insurance obligations, risks, rights, or any combination thereof, of existing or in-force contracts of insurance or reinsurance from a transferring insurer to an assuming insurer. Once approved pursuant to this act, the Insurance Business Transfer will effect a transfer and novation of the transferred contracts of insurance or reinsurance with the result that the assuming insurer becomes directly liable to the policyholders of the transferring insurer and the transferring insurer's insurance obligations or risks, or both, under the contracts are extinguished.

10. "Insurance Business Transfer Plan" or "Plan" means the plan submitted to the Department to accomplish the transfer and novation pursuant to an Insurance Business Transfer including any associated transfer of assets and rights from or on behalf of the transferring insurer to the assuming insurer.

11. "Insurer" means an insurance or surety company including a reinsurance company, and shall be deemed to include a corporation, company, partnership, association, society, order, individual or aggregation of individuals engaging in or proposing or attempting to engage in any kind of insurance or surety business including the exchanging of reciprocal or inter-insurance contracts between individuals, partnerships and corporations.

12. "Petitioner" means an assuming insurer, transferring insurer, or reinsurer petitioning a court for an order of approval and implementation of a Plan pursuant to this act.

13. "Policy" means a policy, annuity contract or certificate of insurance or a contract of reinsurance pursuant to which the insurer agrees to assume an obligation or risk, or both, of the policyholder or to make payments on behalf of, or to, the policyholder or its beneficiaries, and shall include property, casualty, life, health

and any other line of insurance the Commissioner finds, pursuant to this act, is suitable for an insurance business transfer.

14. "Policyholder" means an insured or a reinsured under a policy which is part of the subject business.

15. "Subject business" means the policy or policies designated for transfer and novation pursuant to a corresponding Insurance Business Transfer Plan.

16. "Transfer and novation" means the transfer of insurance obligations, risks, rights, or any combination thereof, of existing or in-force policies from a transferring insurer to an assuming insurer, and is intended to effect a transfer and novation of the transferred policies with the result that the assuming insurer becomes directly liable to the policyholders of the transferring insurer on the transferred policies and the transferring insurer's insurance obligations, risks, rights, or any combination thereof, under the transferred policies are extinguished.

17. "Transferring insurer" means an insurer or reinsurer which seeks to or has accomplished a transfer and novation of obligations, risks, rights, or any combination thereof, under one or more policies to an assuming insurer pursuant to an Insurance Business Transfer Plan and the provisions of this act.

Added by Laws 2018, c. 232, § 3, eff. Nov. 1, 2018. Amended by Laws 2019, c. 381, § 2, eff. Nov. 1, 2019; Laws 2022, c. 126, § 1, emerg. eff. April 29, 2022.

§36-1684. Jurisdiction - Venue.

A. The court considering petitions brought under the Insurance Business Transfer Act shall have the same jurisdiction as a court order under Article 19 of this title.

B. Venue for all court proceedings under this act shall lie in the court as defined pursuant to subsection 4 of Section 1683 of this title.

C. Notwithstanding any other provision of law, the court may issue any order, process, or judgment necessary or appropriate to carry out the provisions of this act. No provision of this act shall be construed to preclude the court from, on its own motion, taking any action or making any determination necessary or appropriate to enforce or implement court orders or rules, or to prevent an abuse of power.

Added by Laws 2018, c. 232, § 4, eff. Nov. 1, 2018. Amended by Laws 2022, c. 126, § 2, emerg. eff. April 29, 2022.

§36-1685. Notice.

A. Whenever notice is required to be given under the Insurance Business Transfer Act and except as otherwise permitted or directed by the court or the Insurance Commissioner, the notice shall be

transmitted within forty-five (45) days of the event triggering the requirement:

1. By first-class mail, postage prepaid to the chief insurance regulator in each jurisdiction in which the transferring insurer:

- a. holds or has ever held a certificate of authority, and
- b. in which policies that are part of the subject business were issued or policyholders currently reside;

2. By certified first-class mail, postage prepaid to the National Conference of Insurance Guaranty Funds, the National Organization of Life and Health Insurance Guaranty Associations and all state insurance guaranty associations for the states in which the transferring insurer:

- a. holds or has ever held a certificate of authority, and
- b. in which policies that are part of the subject business were issued or policyholders currently reside;

3. To reinsurers of the transferring insurer pursuant to the notice provisions of the reinsurance agreements applicable to the policies that are part of the subject business, or where an agreement has no provision for notice, by internationally recognized delivery service;

4. By United States mail, first-class postage prepaid, or by any internationally recognized delivery service, to all policyholders holding policies that are part of the subject business, at their last-known address as indicated by the records of the transferring insurer or to the address to which premium notices or other policy documents are sent. Notice shall also be sent to the transferring insurer's agents or brokers of record on the subject business;

5. By electronic means to any person or entity identified in subsection A of this section who provided consent to notice or service in an agreement included in or related to the subject business or otherwise consents in writing to receiving service by electronic mail and provides instructions for making the electronic notice or service. For the purposes of this subsection, "electronic means" shall include communications by facsimile or electronic mail; and

6. By publication in a newspaper of general circulation in the state in which the transferring insurer has its principal place of business and in such other publications that the Commissioner requires.

B. If notice is given in accordance with this section, any information or orders under this act shall be conclusive with respect to all intended recipients of the notice, whether or not the intended recipients receive actual notice.

C. Where this act requires that the applicant or petitioner provide notice, but a receiver of the insurer has been appointed pursuant to the laws of the insurer's home jurisdiction, the receiver shall provide the required notice.

Added by Laws 2018, c. 232, § 5, eff. Nov. 1, 2018. Amended by Laws 2022, c. 126, § 3, emerg. eff. April 29, 2022.

§36-1686. Application for Approval of Insurance Business Transfer Plan.

A. Application to the Commissioner for Approval of Insurance Business Transfer Plan.

1. An Insurance Business Transfer Plan must be filed by the applicant with the Insurance Commissioner for his or her review and approval. The Plan must contain the information set forth below or an explanation as to why the information is not included. The Plan may be supplemented or revised with additional, updated, or other information as it becomes available or when deemed necessary by the Commissioner:

- a. the name, address and telephone number of the transferring insurer and the assuming insurer and their respective direct and indirect controlling persons, if any,
- b. summary of the Insurance Business Transfer Plan,
- c. identification and description of the subject business,
- d. most recent audited financial statements and statutory annual and quarterly reports of the transferring insurer and assuming insurer filed with their domiciliary regulator,
- e. the most recent actuarial report and opinion that quantify the liabilities associated with the subject business,
- f. pro-forma financial statements showing the projected statutory balance sheet, results of operations and cash flows of the assuming insurer for the three (3) years following the proposed transfer and novation,
- g. officers' certificates of the transferring insurer and the assuming insurer attesting that each has obtained all required internal approvals and authorizations regarding the Insurance Business Transfer Plan and completed all necessary and appropriate actions relating thereto,
- h. proposal for Plan implementation and administration,
- i. form of notice to be provided under the Insurance Business Transfer Plan to any policyholder whose policy is part of the subject business including full description as to how such notice shall be provided,

- j. description of any reinsurance arrangements that will pass to the assuming insurer under the Insurance Business Transfer Plan,
- k. description of any guarantees or additional reinsurance that will cover the subject business following the transfer and novation,
- l. a statement describing the assuming insurer's proposed investment policies and any contemplated third-party claims management and administration arrangements,
- m. evidence of approval or nonobjection of the transfer from the chief insurance regulator of the state of the transferring insurer's domicile, and
- n. an opinion report from an independent expert, which shall provide the following:
 - (1) a statement of the independent expert's professional qualifications and descriptions of the experience that qualifies him or her as an expert suitable for the engagement,
 - (2) whether the independent expert has, or has had, direct or indirect interest in the transferring or assuming insurer or any of their respective affiliates,
 - (3) the scope of the report,
 - (4) a summary of the terms of the Insurance Business Transfer Plan to the extent relevant to the report,
 - (5) a listing and summaries of documents, reports and other material information the independent expert has considered in preparing the report and whether any information requested was not provided,
 - (6) the extent to which the independent expert has relied on information provided by and the judgment of others,
 - (7) the people upon whom the independent expert has relied and why, in his or her opinion, such reliance is reasonable,
 - (8) the independent expert's opinion of the likely effects of the Insurance Business Transfer Plan on policyholders, reinsurers, and claimants, distinguishing between:
 - (a) transferring policyholders, reinsurers, and claimants,
 - (b) policyholders, reinsurers, and claimants of the transferring insurer whose policies will not be transferred, and

- (c) policyholders, reinsurers, and claimants of the assuming insurer,
- (9) for each opinion that the independent expert expresses in the report the facts and circumstances supporting the opinion, and
- (10) consideration as to whether the security position of policyholders that are affected by the Insurance Business Transfer are materially adversely affected by the transfer.

2. The independent expert's opinion report as required by subparagraph n of paragraph 1 of this subsection shall include, but not be limited to, a review of the following:

- a. analysis of the transferring insurer's actuarial review of reserves for the subject business to determine the reserve adequacy,
- b. analysis of the financial condition of the transferring insurer and assuming insurer and the effect the Insurance Business Transfer will have on the financial condition of each insurance company,
- c. review of the plans or proposals the assuming insurer has with respect to the administration of the policies subject to the plan,
- d. whether the proposed transfer has a material adverse effect on the policyholders, reinsurers, and claimants of the transferring and the assuming insurers,
- e. analysis of the assuming insurer's corporate governance structure to ensure proper board and management oversight and expertise to manage the subject business, and
- f. any other information the Commissioner requests in order to review the Insurance Business Transfer.

3. The Commissioner shall have sixty (60) business days from the date of receipt of a complete Insurance Business Transfer Plan to review the Plan to determine if the applicant is authorized to submit it to the court. The Commissioner may extend the sixty-day review period for an additional thirty (30) business days.

4. The Commissioner shall authorize the submission of the Plan to the court unless he or she finds that the Insurance Business Transfer will cause a material adverse effect on the interests of policyholders, reinsurers, or claimants that are part of the subject business.

5. If the Commissioner determines that the Insurance Business Transfer will cause a material adverse effect on the interests of policyholders, reinsurers, or claimants that are part of the subject business, the Commissioner shall notify the applicant and specify any modifications, supplements or amendments and any additional information or documentation with respect to the Plan that must be

provided to the Commissioner before he or she will allow the applicant to proceed with the court filing.

6. The applicant shall have thirty (30) days from the date the Commissioner notifies him or her, pursuant to paragraph 5 of this subsection, to file an amended Insurance Business Transfer Plan providing the modifications, supplements or amendments and additional information or documentation as requested by the Commissioner. If necessary the applicant may request in writing an extension of time of thirty (30) days. If the applicant does not make an amended filing within the time period provided for in this paragraph including any extension of time granted by the Commissioner, the Insurance Business Transfer Plan filing will terminate and a subsequent filing by the applicant will be considered a new filing which shall require compliance with all provisions of this act as if the prior filing had never been made.

7. The Commissioner's review period in paragraph 3 of this subsection shall recommence when the modification, supplement, amendment or additional information requested in paragraph 5 of this subsection is received.

8. If the Commissioner determines that the applicant may proceed with filing a petition with the court seeking approval and implementation of the Plan, the Commissioner shall confirm that fact in writing to the applicant.

B. Petition to the court for approval and implementation of the Insurance Business Transfer Plan.

1. Within thirty (30) days after the filing and transmission of the Commissioner's order determining the Plan satisfies the requirements of this act, the assuming insurer, transferring insurer, or reinsurer may file a petition with the court seeking an order of approval and implementation of the Insurance Business Transfer Plan. Upon written request by the applicant to the Commissioner, the period for filing a petition under this subsection with the court may be extended for an additional thirty (30) days.

2. The petition shall include:

- a. relief sought,
- b. information, arguments, and authorities supporting the requested relief including information and analysis which will support the court's finding that the plan will not result in a material adverse effect to policyholders, reinsurers, or claimants,
- c. the Insurance Business Transfer Plan,
- d. preliminary list of witnesses and exhibits which the petitioner reasonably intends to present to the court, and
- e. request for the court to enter judgment in favor of the petitioner, which shall include finding of fact, conclusion of law, order of approval and

implementation of the Plan, and retention of jurisdiction to allow the parties to request such orders regarding incidental, consequential, and supplementary matters necessary to assure the full and effective implementation of the Plan.

3. The Commissioner shall be a party to the proceedings before the court concerning the petition and shall be served with copies of all filings pursuant to subsection D of Section 2005 of Title 12 of the Oklahoma Statutes and the Rules for District Courts of Oklahoma.

4. The Commissioner's position in the proceeding shall not be limited by his or her initial review of the Plan.

5. Within thirty (30) days after the filing of the petition, the petitioner shall file a request for the court to enter a preliminary scheduling order, which shall include a date and time for a status conference. The status conference shall occur no less than fourteen (14) days after the conclusion of the sixty (60) day comment period required in paragraph 8 of this subsection.

6. Within forty-five (45) days after the court enters the preliminary scheduling order, the petitioner shall cause the transmission and publication of a notice of the matter before the court in accordance with the notice provisions of Section 1685 of this title.

7. The notice shall include:

- a. the date and time of the status conference required in paragraph 5 of this subsection,
- b. the name, address and telephone number of the assuming insurer, transferring insurer, and Commissioner for policyholders to contact to obtain further information,
- c. procedures and deadlines for policyholders, claimants, and third parties to submit comments, objections, and requests to be heard at trial regarding the Plan,
- d. procedure for policyholders to request the petitioner provide one (1) hard copy, free of charge, to policyholders unable to access or acquire an electronic copy of the Plan and associated information, if any,
- e. a summary of the order entered by the Commissioner pursuant to paragraph 8 of subsection A of this section including the effect the plan will have on the policy holders, if any,
- f. name and location of the court in which the petition is filed,
- g. case number, parties, and other identifying information of the matter in the petition,
- h. relief sought in the petition,

- i. procedure to access an electronic copy of the Plan and associated information, if any,
- j. further notice of filings, schedules, orders, and other information will only be provided pursuant to paragraph 10 of this subsection, and
- k. if the Plan is approved by the court, the court shall enter judgment consistent with paragraph 3 of subsection C of this section.

8. The last date of transmission and publication of the notice shall be followed by a comment period no less than sixty (60) days.

9. Any person including by their legal representative, who provides written notice within the sixty (60) day comment period identified in paragraph 8 of this subsection, and states the person considers himself, herself or itself to be materially adversely affected by the approval and implementation of the Plan may present evidence or comments to the court at trial. However, such comment or evidence shall not confer standing as a party on any person. Any person participating in any pretrial proceeding or the trial of petitioner's request for approval and implementation of the Plan must follow the process established by the court and shall bear his or her own costs and attorney fees.

10. Only parties to this matter and those persons and other third parties who file a request to provide comments, objections, or requests to be heard pursuant to paragraph 8 of this subsection shall receive further notice and copies of filings with the court, pursuant to subsection D of Section 2005 of Title 12 of the Oklahoma Statutes and the Rules for District Courts of Oklahoma; provided, however, all persons and other third parties shall receive notice pursuant to subparagraph d of paragraph 3 of subsection C of this section.

11. Within forty-five (45) days of the status conference required pursuant to paragraph 5 of this subsection, the petitioner shall file a motion for a scheduling order and to enter this matter on the court's trial docket.

C. Approval by the court of the Insurance Business Transfer Plan.

1. Pursuant to a scheduling order set forth in paragraph 11 of subsection B of this section, and other orders by the court, the petitioner shall present the Insurance Business Transfer Plan, evidence, and arguments to the court for approval and implementation of the Plan.

2. At any time before the court issues judgment, the petitioner may withdraw the petition without prejudice to refileing.

3. If the court finds that the approval and implementation of the Insurance Business Transfer Plan will not materially adversely affect the interests of policyholders or claimants of policies which

are part of the subject business, the court shall enter judgment in favor of the petitioner. The judgment and order shall include:

- a. findings of fact,
- b. conclusion of law,
- c. approval and implementation of the Plan including:
 - (1) simultaneous transfer and novation from the transferring insurer to the assuming insurer of the subject business with respect to all policyholders, reinsurers, claimants and their respective policies, and reinsurance agreements under the subject business,
 - (2) simultaneous transfer and novation from the transferring insurer and the assuming insurer of all property, rights, obligations, and liabilities including, but not limited to, the ceded reinsurance of transferred policies and contracts included in the subject business, notwithstanding any nonassignment provisions in any such reinsurance contracts or other agreements,
 - (3) assuming insurer shall have all of transferring insurer's rights, obligations, and liabilities regarding the subject business as if it were the original insurer of such policies including the same standing as the transferring insurer pursuant to contract, statute, and interpretation, relating back to the issuance of such policies, and
 - (4) policyholders' and claimants' rights obligations and liabilities, if any, under their respective policies which are part of the subject business shall not be enlarged, extended, limited, or reduced; provided, however, the policyholders and claimants may not pursue or be pursued by the transferring insurer to satisfy their respective rights, obligations, and liabilities, but instead the policyholders and claimants may pursue or be pursued by the assuming insurer,
- d. petitioner to provide notice of the judgment including the resulting transfer and novation in accordance with the notice provisions in Section 1685 of this title,
- e. make such other orders and provisions with respect to incidental, consequential and supplementary matters as are necessary to assure the full and effective implementation of the Insurance Business Transfer Plan, and

f. retain jurisdiction of the matter to allow the parties to request such additional orders regarding incidental, consequential, and supplemental matters necessary to assure the full and effective implementation of the Plan.

4. If the court finds that the Insurance Business Transfer Plan should not be approved, the court by its order may:

- a. deny the petition, or
- b. provide the petitioner leave to file an amended petition including an amended Insurance Business Transfer Plan and petition.

5. Nothing in this section in any way affects the right of appeal of any party.

D. An unexpired and in-force policy issued to a policyholder who resides in a state other than Oklahoma shall not be transferred and novated unless or until the assuming insurer is licensed, authorized, permitted, or otherwise legally allowed to administer the subject business in the same manner as the transferring insurer in the state of the policyholder's residence.

E. The court may approve the requested transfer and novation of the subject business, with effectiveness of all or part of the implementation deferred until the assuming insurer can satisfy the requirements pursuant to subsection D of this section.

F. Rules.

The Commissioner shall have the authority to promulgate rules to effectuate the provisions of the Insurance Business Transfer Act.

G. All testimony, documents, exhibits, analysis, communications, or other information or evidence submitted to the Commissioner or independent expert in contemplation of an application, submitted to the court in support of a petition, or developed by the Commissioner or independent expert in connection with such application, or petition for approval and implementation of an Insurance Business Transfer Plan, shall be treated for purposes of confidentiality as an examination of the financial condition and/or market conduct of the transacting companies under Sections 309.1 through 309.7 of this title.

Added by Laws 2018, c. 232, § 6, eff. Nov. 1, 2018. Amended by Laws 2019, c. 381, § 3, eff. Nov. 1, 2019; Laws 2022, c. 126, § 4, emerg. eff. April 29, 2022.

§36-1687. Consent to jurisdiction of Commissioner.

Insurers subject to this act consent to the jurisdiction of the Insurance Commissioner with regard to ongoing oversight of operations, management and solvency relating to the transferred business, including the authority of the Commissioner to conduct financial analysis and examinations.

Added by Laws 2018, c. 232, § 7, eff. Nov. 1, 2018.

§36-1688. Fees - Reimbursement - Costs.

A. At the time of filing its application with the Insurance Commissioner for review and approval of an Insurance Business Transfer Plan, the applicant shall pay a nonrefundable fee to the Insurance Department in the amount of Ten Thousand Dollars (\$10,000.00).

B. In the Commissioner's discretion, in connection with the Department's participation in the proceedings undertaken pursuant to the Insurance Business Transfer Act, the applicant shall reimburse the Department for any compensation and benefits paid to the personnel of the Department for time spent engaged in the proceedings, including but not limited to examiners, actuaries, attorneys, managers and paraprofessionals.

C. The Commissioner may retain independent attorneys, appraisers, actuaries, certified public accountants, or other professionals and specialists to assist Department personnel in connection with the review required by the Insurance Business Transfer Act, the cost of which shall be borne by the applicant.

D. The applicant shall pay the expenses of the Department and its authorized consultants incurred in fulfilling their obligations under this act, including the actual expenses of the Department or the expenses and compensation of any consultants retained by the Department.

E. The transferring insurer and the assuming insurer shall jointly be obligated to pay any compensation, costs and expenses of the independent expert and any consultants retained by the independent expert and approved by the Department incurred in fulfilling the obligations of the independent expert under this act. Nothing in this act shall be construed to create any duty for the independent expert to any party other than the Department or the Court.

F. Failure to pay any of the requisite fees or reimbursements within thirty (30) days of demand shall be grounds for the Commissioner to request that the court dismiss the petition for approval of the Insurance Business Transfer Plan prior to the filing of an implementation order by the court or, if after the filing of an implementation order, the Commissioner may suspend or revoke the assuming insurer's certificate of authority to transact insurance business in this state.

Added by Laws 2018, c. 232, § 8, eff. Nov. 1, 2018. Amended by Laws 2019, c. 381, § 4, eff. Nov. 1, 2019.

§36-1691. Short title - Protected Cell Companies Act.

This act shall be known and may be cited as the "Protected Cell Companies Act".

Added by Laws 2019, c. 362, § 1, eff. Nov. 1, 2019.

§36-1692. Purpose of act.

The Protected Cell Companies Act is adopted to provide a basis for the creation of protected cells by a domestic insurer as a means of accessing alternative sources of capital and achieving the benefits of insurance securitization or effectuating insurance business transfers in accordance with the Insurance Business Transfer Act. Investors in fully funded insurance securitization transactions provide funds that are available to pay the insurer's insurance obligations or to repay investors or both. The creation of protected cells is intended to be a means to achieve more efficiencies in conducting insurance securitizations or insurance business transfers.

Added by Laws 2019, c. 362, § 2, eff. Nov. 1, 2019.

§36-1693. Definitions.

As used in the Protected Cell Companies Act:

1. "Commissioner" means the Oklahoma Insurance Commissioner;
2. "Domestic insurer" means an insurance or reinsurance company domiciled in the State of Oklahoma or a captive insurance or reinsurance company domiciled in the State of Oklahoma;
3. "Fair value" of an asset or liability means the monetary amount at which that asset or liability could be bought, incurred, sold or settled in a current transaction between willing parties other than in a forced or liquidation sale. Quoted market prices in active markets are the best evidence of fair value and shall be used as the basis for the measurement, if available. If a quoted market price is available, the fair value is the product of the number of trading units times market price. If quoted market prices are not available, the estimate of fair value shall be based on the best information available. The estimate of fair value shall consider prices for similar assets and liabilities and the results of valuation techniques to the extent available in the circumstances. Examples of valuation techniques include the present value of estimated expected future cash flows using a discount rate commensurate with the risks involved, option pricing models, matrix pricing, option-adjusted spread models and fundamental analysis. Valuation techniques for measuring financial assets and liabilities and servicing assets and liabilities shall be consistent with the objective of measuring fair value. Those techniques shall incorporate assumptions that market participants would use in their estimates of values, future revenues and future expenses, including assumptions about interest rates, default, prepayment and volatility. When measuring financial liabilities and servicing liabilities at fair value by discounting estimated future cash flows, the objective is to use discount rates at which those liabilities could be settled in an arm's-length transaction.

Estimates of expected future cash flows, if used to estimate fair value, shall be the best estimate based on reasonable and supportable assumptions and projections. All available evidence shall be considered in developing estimates of expected future cash flows. The weight given to the evidence shall be commensurate with the extent to which the evidence can be verified objectively. If a range is estimated for the amount or timing of possible cash flows, the likelihood of possible outcomes shall be considered in determining the best estimate of future cash flows;

4. "Fully funded" means that, with respect to any exposure attributed to a protected cell, the fair value of the protected cell assets, on the date on which the insurance securitization is effected, equals or exceeds the maximum possible exposure attributable to the protected cell with respect to those exposures;

5. "General account" means the assets and liabilities of a protected cell company other than protected cell assets and protected cell liabilities;

6. "Indemnity trigger" means a transaction term by which relief of the issuer's obligation to repay investors is triggered by the issuer incurring a specified level of losses under its insurance or reinsurance contracts;

7. "Nonindemnity trigger" means a transaction term by which relief of the issuer's obligation to repay investors is triggered solely by some event or condition other than the individual protected cell company incurring a specified level of losses under its insurance or reinsurance contracts;

8. "Protected cell" means an identified pool of assets and liabilities of a protected cell company segregated and insulated by means of this act from the remainder of the protected cell company's assets and liabilities;

9. "Protected cell account" means a specifically identified bank or custodial account established by a protected cell company for the purpose of segregating the protected cell assets of one protected cell from the protected cell assets of other protected cells and from the assets of the protected cell company's general account;

10. "Protected cell assets" means all assets, contract rights and general intangibles identified with and attributable to a specific protected cell of a protected cell company;

11. "Protected cell company" means a domestic insurer that has one or more protected cells;

12. "Protected cell company insurance securitization" means the issuance of debt instruments, the proceeds from which support the exposures attributed to the protected cell, by a protected cell company, where repayment of principal and/or interest to investors pursuant to the transaction terms is contingent upon the occurrence or nonoccurrence of an event with respect to which the protected

cell company is exposed to loss under insurance or reinsurance contracts it has issued;

13. "Protected cell liabilities" means all liabilities and other obligations identified with and attributable to a specific protected cell of a protected cell company; and

14. "Receiver" means the Commissioner, where the Commissioner is acting as a rehabilitator, liquidator or administrative supervisor of a company, or any person appointed to carry out an order of rehabilitation or liquidation of a company.

Added by Laws 2019, c. 362, § 3, eff. Nov. 1, 2019.

§36-1694. Establishment of protected cells - Plan of operation.

A. A protected cell company may establish one or more protected cells, with the prior written approval of the Insurance Commissioner of a plan of operation or amendments to a plan of operation submitted by the protected cell company with respect to each protected cell. Upon the written approval of the Commissioner of the plan of operation or amendments to a plan of operation, which shall include, but not be limited to, the specific business objectives and investment guidelines of the protected cell, the protected cell company may, in accordance with the approved plan of operations, attribute to the protected cell amounts both reflective of insurance obligations with respect to its insurance business and obligations relating to the insurance securitization and assets to fund the obligations. Each protected cell of a protected cell company shall have its own distinct name or designation, which shall include the words "protected cell". The protected cell company shall transfer all assets attributable to each protected cell to one or more separately established and identified protected cell accounts bearing the name or designation of that protected cell. Protected cell assets shall be held in the protected cell accounts for the purpose of satisfying the obligations of that protected cell.

B. All attributions of assets and liabilities between a protected cell and the general account shall be in accordance with the plan of operation approved by the Commissioner or shall be otherwise approved by the Commissioner. Unless otherwise approved by the Commissioner, no other attribution of assets or liabilities shall be made by a protected cell company between the protected cell company's general account and one or more of its protected cells. Any attribution of assets and liabilities between the general account and a protected cell, or from investors in the form of principal on a debt instrument issued by a protected cell company in connection with a protected cell company securitization, shall be in cash or readily marketable securities with established market values unless otherwise approved in advance in writing by the Commissioner.

C. The creation of a protected cell does not create, in respect of that protected cell, a legal person separate from the protected cell company. Amounts attributed to a protected cell under this act, including assets transferred to a protected cell account, are owned by the protected cell company and the protected cell company may not be, nor hold itself out to be, a trustee with respect to those protected cell assets of that protected cell account. Notwithstanding the foregoing, the protected cell company may allow for a security interest to attach to protected cell assets or a protected cell account when in favor of a creditor of the protected cell and otherwise allowed under applicable law.

D. Nothing in the Protected Cell Companies Act shall be construed to prohibit the protected cell company from contracting with or arranging for an investment advisor, commodity trading advisor or other third party to manage the protected cell assets of a protected cell, provided that all remuneration, expenses and other compensation of the third-party advisor or manager are payable from the protected cell assets of that protected cell and not from the protected cell assets of other protected cells or the assets of the protected cell company's general account. The contract shall clearly reference the protected cell or cells for which the contract has been arranged and shall contain a nonrecourse provision in favor of the company that prohibits the contracting party from seeking recourse against, or attaching the assets of the general account, or the assets of another protected cell, to satisfy the obligations of any one or more protected cells which are the subject of the contract.

E. A protected cell company shall establish any administrative and accounting procedures that are necessary to properly identify the one or more protected cells of the protected cell company and the protected cell assets and protected cell liabilities attributable to the protected cells. It shall be the duty of the directors of a protected cell company to:

1. Keep protected cell assets and protected cell liabilities separate and separately identifiable from the assets and liabilities of the protected cell company's general account; and

2. Keep protected cell assets and protected cell liabilities attributable to one protected cell separated and separately identifiable from protected cell assets and protected cell liabilities attributable to other protected cells.

Notwithstanding other provisions of this section, if this section is violated, the remedy of tracing shall be applicable to protected cell assets when commingled with protected cell assets of other protected cells or the assets of the protected cell company's general account. The remedy of tracing shall not be construed as an exclusive remedy.

F. Unless otherwise approved by the Commissioner, the protected cell company shall, when establishing a protected cell, attribute the protected cell assets a value at least equal to the reserves and other insurance liabilities attributed to that protected cell. Added by Laws 2019, c. 362, § 4, eff. Nov. 1, 2019.

§36-1695. Assets and liabilities of protected cells - Protected cell income - Insurance securitization.

A. The protected cell assets of any protected cell shall not be charged with liabilities arising out of any other business the protected cell company may conduct. All contracts or other documentation reflecting protected cell liabilities shall clearly indicate that only the protected cell assets are available for the satisfaction of those protected cell liabilities.

B. Unless otherwise approved by the Insurance Commissioner, assets attributed to a protected cell shall be valued at their fair value on the date of valuation.

C. The income, gains and losses, realized or unrealized, from protected cell assets and protected cell liabilities shall be credited to or charged against the protected cell without regard to other income, gains or losses of the protected cell company, including income, gains or losses of other protected cells. Amounts attributed to any protected cell and accumulations on the attributed amounts may be invested and reinvested without regard to any requirements or limitations imposed on investments of insurance companies domiciled in this state and the investments in any protected cell or cells may not be taken into account in applying the investment limitations otherwise applicable to the investments of the protected cell company, subject to any restrictions that may be imposed by the Commissioner in accordance with Section 9 of this act.

D. As permitted by the Commissioner, a protected cell company may, in respect of any of its protected cells, engage in fully funded indemnity triggered and/or fully funded nonindemnity triggered insurance securitization to support in full the protected cell exposures attributable to that protected cell. A protected cell company insurance securitization that is nonindemnity triggered shall qualify as an insurance securitization under the terms of this section only after the Commissioner, in accordance with the authority granted under Section 9 of this act, adopts regulations addressing the methods of funding of the portion of the risk that is not indemnity-based, accounting, disclosure, risk-based capital treatment, and assessing risks associated with those securitizations. A protected cell company insurance securitization that is not fully funded, whether indemnity triggered or nonindemnity triggered, is prohibited. Protected cell assets may be used to pay interest or other consideration on any outstanding debt

or other obligation attributable to that protected cell, and nothing in this section shall be construed or interpreted as preventing a protected cell company from entering into a swap agreement or other transaction for the account of the protected cell that has the effect of guaranteeing that interest or other consideration.

E. In all protected cell company insurance securitizations, the contracts or other documentation effecting the transaction shall contain provisions identifying the protected cell to which the transaction will be attributed. In addition, the contracts or other documentation shall clearly disclose that the assets of that protected cell, and only those assets, are available to pay the obligations of that protected cell. Notwithstanding the foregoing, and subject to the provisions of this title and any other applicable law or rules, the failure to include that language in the contracts or other documentation shall not be used as the sole basis by creditors, reinsurers or other claimants to circumvent the provisions of this section.

F. At the cessation of business of a protected cell, and in absence of any placement under administrative supervision or order of conservation, rehabilitation or liquidation attributable to that protected cell or the protected cell company, the protected cell company shall voluntarily close out the protected cell account in accordance with a plan approved by the Commissioner.

G. A protected cell company shall only be authorized to attribute to a protected cell account the insurance obligations relating to the protected cell company's general account. Under no circumstances shall a protected cell be authorized to issue insurance or reinsurance contracts directly to policyholders or reinsureds or have any obligation to the policyholders or reinsureds of the protected cell company's general account.

Added by Laws 2019, c. 362, § 5, eff. Nov. 1, 2019.

§36-1696. Creditors of protected cells - Obligation of protected cell company.

A. 1. Protected cell assets shall only be available to the creditors of the protected cell company that are creditors in respect to that protected cell and shall be entitled, in conformity with the provisions of the Protected Cell Companies Act, to have recourse to the protected cell assets attributable to that protected cell, and shall be absolutely protected from the creditors of the protected cell company that are not creditors in respect of that protected cell and, who accordingly, shall not be entitled to have recourse to the protected cell assets attributable to that protected cell. Creditors, with respect to a protected cell, shall not be entitled to have recourse against the protected cell assets of other protected cells or the assets of the protected cell company's general account.

2. Protected cell assets shall only be available to creditors of a protected cell company after all protected cell liabilities have been extinguished or provided for in accordance with the plan of operation relating to that protected cell.

B. When an obligation of a protected cell company to a person arises from a transaction, or is imposed, with respect to a protected cell:

1. That obligation of the protected cell company shall extend only to the protected cell assets attributable to that protected cell, and the person shall, with respect to that obligation, be entitled to have recourse only to the protected cell assets attributable to that protected cell; and

2. That obligation of the company shall not extend to the protected cell assets of any other protected cell or the assets of the protected cell company's general account, and that person shall not, with respect to that obligation, be entitled to have recourse to the protected cell assets of any other protected cell or the assets of the protected cell company's general account.

C. When an obligation of a protected cell company relates solely to the general account, the obligation of the protected cell company shall extend only to, and that creditor shall, with respect to that obligation, be entitled to have recourse only to, the assets of the protected cell company's general account.

D. Other than with regard to the application of this section, the activities, assets and obligations relating to a protected cell are not subject to the provisions of Articles 20A and 20B of Title 36 of the Oklahoma Statutes. Neither a protected cell nor a protected cell company shall be assessed by or be required to contribute to any guaranty fund or guaranty association in this state with respect to the activities, assets or obligations of a protected cell. Nothing in this section shall affect the activities or obligations of an insurer's general account.

E. In no event shall the establishment of one or more protected cells alone constitute or be deemed to be a fraudulent conveyance, an intent by the protected cell company to defraud creditors, or the carrying out of business by the protected cell company for any other fraudulent purpose.

Added by Laws 2019, c. 362, § 6, eff. Nov. 1, 2019.

§36-1697. Receivership - Amounts recoverable.

A. Notwithstanding any contrary provision in the Oklahoma Insurance Code, the rules promulgated under the Oklahoma Insurance Code or any other applicable law or rule, upon placement under administrative supervision or upon any order of conservation, rehabilitation or liquidation of a protected cell company, the receiver shall be bound to deal with the protected cell company's assets and liabilities, including protected cell assets and

protected cell liabilities, in accordance with the requirements set forth in the Protected Cell Companies Act.

B. With respect to amounts recoverable under a protected cell company insurance securitization, the amount recoverable by the receiver shall not be reduced or diminished as a result of the placement under administrative supervision or entry of an order of conservation, rehabilitation or liquidation with respect to the protected cell company or any of its protected cells, notwithstanding any provisions to the contrary in the contracts or other documentation governing the protected cell company insurance securitization.

Added by Laws 2019, c. 362, § 7, eff. Nov. 1, 2019.

§36-1698. Insurance securitization - Not deemed an insurance or reinsurance contract.

A protected cell company insurance securitization shall not be deemed to be an insurance or reinsurance contract. An investor in a protected cell company insurance securitization shall not, by sole means of this investment, be deemed to be transacting an insurance business in this state. The underwriters or selling agents and their partners, directors, officers, members, managers, employees, agents, representatives and advisors involved in a protected cell company insurance securitization shall not be deemed to be conducting an insurance or reinsurance agency, brokerage, intermediary, advisory or consulting business by virtue of their activities in connection with those businesses.

Added by Laws 2019, c. 362, § 8, eff. Nov. 1, 2019.

§36-1699. Promulgation of rules.

The Insurance Commissioner may promulgate reasonable rules as may be necessary to effectuate the purposes of the Protected Cell Companies Act.

Added by Laws 2019, c. 362, § 9, eff. Nov. 1, 2019.

§36-1701. Deposits of insurers.

The Insurance Commissioner of Oklahoma shall accept and hold in trust deposits of securities or funds by insurers as follows:

1. Deposits required for authority to transact insurance in Oklahoma;

2. Deposits of domestic, foreign, or alien insurers when made pursuant to the laws of other states, provinces, and countries as prerequisite for authority to transact insurance in such state, province, or country; and

3. Deposits in such additional amounts as are permitted to be made by Section 1706 of this title.

Added by Laws 1957, p. 291, § 1701, operative July 1, 1957. Amended by Laws 2014, c. 275, § 8, eff. Nov. 1, 2014.

§36-1702. Purpose of deposits.

Such deposits shall be held as follows:

1. When the deposit is required for authority to transact insurance in Oklahoma the deposit shall be held for the protection of all the insurer's policyholders and/or creditors within the United States.

2. When the deposit is required pursuant to the laws of another state, province, or country, the deposit shall be held for such purposes as is required by such laws, and as specified by the Insurance Commissioner at the time the deposit is made.

3. When the deposit is required pursuant to the retaliatory provision, Section 630 of Article 6 (Authorization of Insurers and General Requirements Article), the deposit shall be held for purposes as specified in the Insurance Commissioner's order requiring the deposit.

Laws 1957, p. 291, § 1702; Laws 1969, c. 122, § 1, emerg. eff. April 3, 1969.

§36-1703. Assets eligible for deposit.

A. All such deposits required for authority to transact insurance business in Oklahoma shall consist of cash, under negotiable and transferable certificates of deposit or other time deposit instruments issued by solvent insured banks, savings and loan associations, and trust companies in Oklahoma, or a combination of the foregoing and the securities described in Sections 1607, 1608, 1609 and 1620 of this title.

B. All such deposits required pursuant to the laws of another state, province, or country, or pursuant to the retaliatory provision of Section 628 of this title, shall consist of such assets as are required or permitted by such laws, or as required pursuant to such retaliatory provision.

Added by Laws 1957, p. 292, § 1703, operative July 1, 1957. Amended by Laws 1963, c. 111, § 1, emerg. eff. May 31, 1963; Laws 1986, c. 251, § 27, eff. Nov. 1, 1986; Laws 1987, c. 175, § 19, eff. Nov. 1, 1987; Laws 1990, c. 297, § 2, eff. Sept. 1, 1990; Laws 2012, c. 44, § 9, eff. Nov. 1, 2012.

§36-1704. Trust companies as depositaries.

A. Upon request of the insurer, the Insurance Commissioner may designate any solvent trust company or other solvent financial institution having trust powers domiciled in this State as the Commissioner's depositary to receive and hold any such deposit. Any such deposit so held shall be at the expense of the insurer.

B. The State of Oklahoma shall be responsible for the safekeeping and return of all funds and securities deposited

pursuant to this Code with the Commissioner or in any depository so designated by the Commissioner.

Added by Laws 1957, p. 292, § 1704, operative July 1, 1957. Amended by Laws 2014, c. 275, § 9, eff. Nov. 1, 2014.

§36-1705. Rights of insurer during solvency.

So long as the insurer remains solvent and complies with this Code it may:

1. Demand, receive, sue for and recover the income from the securities or cash deposited;

2. Exchange and substitute for the deposited cash or securities, or any part thereof, cash or eligible securities of equivalent or greater value; and

3. Inspect, at reasonable times, any such deposit.

Laws 1957, p. 292, § 1705.

§36-1706. Excess deposits.

An insurer may so deposit cash or eligible securities in an amount exceeding its deposit required or otherwise permitted under this Code, for the purpose of absorbing fluctuations in the value of securities held in its deposit, and to facilitate the exchange and substitution of securities deposited. During the solvency of the insurer any such excess deposit or part thereof shall be released to the insurer upon its request. During the insolvency of the insurer such excess deposit shall be released only as provided in Section 1707 of this article.

Amended by Laws 1985, c. 328, § 11, emerg. eff. July 29, 1985.

§36-1707. Release of deposits.

Any deposit made in this state under the Insurance Code shall be released and returned:

1. To the insurer upon extinguishment by reinsurance or otherwise of substantially all liability of the insurer for the security of which the deposit is held upon proper request by the insurer and after financial review of the insurer proving generally acceptable financial conditions;

2. To the insurer to the extent such deposit is in excess of the amount required upon proper request by the insurer and after financial review of the insurer proving generally acceptable financial conditions; or

3. Upon proper order of a court of competent jurisdiction to the receiver, conservator, rehabilitator or liquidator of the insurer, or to any other properly designated official or officials who succeed to the management and control of the insurer's assets.

Added by Laws 1957, p. 292, § 1707, operative July 1, 1957. Amended by Laws 2012, c. 44, § 10, eff. Nov. 1, 2012.

§36-1708. Release only on order.

No such release of deposited funds shall be made except upon application to and the written order of the Insurance Commissioner. The Insurance Commissioner shall have no liability for any such release of any such deposit or part thereof so made by it in good faith.

Laws 1957, p. 292, § 1708.

§36-1709. Deposit not subject to levy.

No judgment creditor or other claimant of an insurer shall levy upon any deposit held pursuant to this Code, or upon any part thereof; except, that such levy may be permitted if so specified in the Insurance Commissioner's order requiring the deposit pursuant to the retaliatory provision, Section 630 of Article 6 (Authorization of Insurers and General Requirements).

Laws 1957, p. 293, § 1709.

§36-1801. Legislative findings and purposes.

A. The Legislature finds that:

1. Existing provisions of law and present procedures are sometimes not adequate nor appropriate under all circumstances in order to remedy the financial condition and the management of certain insurers;
2. Present laws are not adequate for the rehabilitation of insurers who voluntarily request rehabilitation;
3. A void exists in the laws with respect to those insurers most susceptible to rehabilitation or the regaining of solvency;
4. The placing of an insurer in receivership often destroys or diminishes, or is likely to destroy or diminish, one or more of the following values or assets:
 - a. the value of the insurance account or in-force business of the insurer,
 - b. the value of the insurer as a going concern,
 - c. the value of its agency force, and
 - d. the value of other of its assets;
5. Such values and assets should be preserved if the circumstances of the insurer's financial condition warrant an attempt to conserve or rehabilitate such insurer and such rehabilitation or conservation is otherwise feasible;
6. In the event receivership ultimately becomes necessary, preliminary supervision and conservatorship is preventive of a dissipation of assets and will thus benefit policyholders, creditors and owners;
7. Insurer delinquency, or the state's inability to properly proceed in a threatened delinquency, directly or indirectly affects other insurers by creating a lack of public confidence in insurance and in insurance companies and are destructive of public confidence

in the capacity of the state to regulate insurers, and these and other harmful results of insurer delinquency are properly minimized by a further enactment designed to protect and in aid of insureds, creditors and owners; and

8. It is a proper concern of this state to attempt to correct or remedy insurer misconduct, ineptness or misfortune.

B. It is the purpose of this act to:

1. Provide for rehabilitation and conservation of insurers by authorizing and requiring the additional facility of supervision and conservatorship by the Insurance Commissioner, authorize action to resolve whether an attempt be made to rehabilitate and conserve an insurer, and avoid, if possible and feasible, the necessity of temporary or permanent receivership;

2. Provide for protection of the assets of an insurer pending determination of whether or not an insurer can be successfully rehabilitated; and

3. Provide a facility and direction for attempting the rehabilitation without immediate resort to the harsher remedy of receivership.

C. The substance and procedure of this act is, therefore, declared to be the public policy of this state and necessary to the public welfare. Such policy and welfare require the availability of the remedies provided by this law whenever circumstances warrant, and it is a condition of doing an insurance business in this state. Laws 1975, c. 316, § 1, emerg. eff. June 12, 1975.

§36-1802. Definitions.

As used in Article 18 of the Insurance Code, the following words and terms set forth below shall have the meanings ascribed to them unless the context otherwise indicates:

1. "Commissioner" means the Insurance Commissioner of this state;

2. "Insurer" is a person, organization, association or company, authorized or unauthorized, admitted or nonadmitted, acting as an insurer, or as principal or agent of an insurer, including any domestic, foreign or alien insurer, as defined in Article 6 of the Insurance Code, and including stock companies, reciprocals or insurance exchanges, Lloyds Associations, fraternal benefit societies, stipulated premium companies, and mutual companies of all kinds, including statewide mutual assessment corporations, local mutual aids, burial associations, county mutual insurance companies and farm mutual insurance companies, and health maintenance organizations;

3. "Insolvent" or "insolvency" means any actual or threatened insurer delinquency including, but not limited to, any one or more of the following circumstances:

- a. an insurer's required surplus or capital is impaired to an extent prohibited by law,
- b. an insurer continues to write new business when it is not possessed of the surplus or capital required of it by law,
- c. the business of any such insurer is being conducted fraudulently,
- d. any such insurer attempts to dissolve or liquidate without first having made provisions, satisfactory to the Commissioner, for liabilities arising from policies of insurance issued by such insurer; or
- e. the insurer has made investments in violation of the Insurance Code or has knowingly over-valued insurer's assets;

4. "Exceeded its powers" includes, but is not limited to, the following circumstances:

- a. an insurer's refusal to permit examination of its books, papers, accounts, records or affairs by the Commissioner, his or her deputy or duly-commissioned examiners; or if such insurer being organized in the State of Oklahoma removes from the state such books, papers, accounts or records necessary for an examination of such insurer,
- b. an insurer's failure to promptly answer inquiries authorized by Section 1905(6) of this title,
- c. an insurer's neglect or refusal to observe an order of the Commissioner to make good, within the time prescribed by law, any prohibited deficiency in its capital or surplus,
- d. an insurer, without first obtaining written approval of the Commissioner, by contract or otherwise:
 - (1) totally reinsuring its entire outstanding business, or
 - (2) merging or consolidating substantially its entire property or business with another approved insurer, or
- e. an insurer continuing to write business after its license has been revoked or suspended; and

5. "Consent" means any agreement by the insurer to either supervision or conservatorship.

Added by Laws 1975, c. 316, § 2, emerg. eff. June 12, 1975. Amended by Laws 2003, c. 197, § 56, eff. Nov. 1, 2003.

§36-1803. Duties of Commissioner.

A. The Insurance Commissioner shall, if there is substantial reason to believe that any insurer is insolvent, or if any insurer's condition is such as to render the continuance of its business

hazardous to the public or to holders of its policies or certificates of insurance, or it has exceeded its powers, or it has failed to comply with the law, or if such insurer gives its consent:

1. Notify the insurer of the Commissioner's determination;
2. Furnish the insurer a written list of requirements to abate the Commissioner's determination; and
3. If the Commissioner makes a further determination to supervise, notify the insurer that it is under supervision pursuant to this article.

B. Such insurer shall comply with the lawful requirements of the Commissioner and, if placed under supervision, shall have ninety (90) days from the date of notice within which to comply with the requirements of the Commissioner unless the Commissioner designates a lesser or greater period of time or unless the Commissioner determines at any time during or after the ninety-day period of time that judicial or administrative proceedings should be initiated to place such insurer in conservation, rehabilitation or liquidation proceedings or other delinquency proceedings, pursuant to Articles 18 and 19 of this title. If such insurer does not comply with such requirements, such supervision may continue until such requirements are remedied or until the Commissioner approves or completes pursuit of additional options as provided in the Insurance Code.

Added by Laws 1975, c. 316, § 3, emerg. eff. June 12, 1975. Amended by Laws 1985, c. 328, § 12, emerg. eff. July 29, 1985; Laws 2002, c. 307, § 25, eff. Nov. 1, 2002.

NOTE: A former § 1803 of this title was renumbered as § 1903 of this title by Laws 1975, c. 316, § 12, emerg. eff. June 12, 1975.

§36-1804. Appointment of supervisor - Acts prohibited - Additional requirements.

A. During any period of supervision, the Commissioner may appoint a supervisor for such insurer and provide that the insurer may not do any of the following things without the prior approval of the Commissioner or his supervisor:

1. Dispose, convey or encumber any of its assets or its business in force;

2. Withdraw funds from bank accounts;
3. Lend funds;
4. Invest funds;
5. Transfer property;
6. Incur any debt, obligation or liability;
7. Merge or consolidate with another company; or
8. Enter into any new reinsurance contract or treaty.

B. In addition, the Commissioner may require of the insurer, the following:

1. Periodic actuarial reviews;

2. That the insurer limit or cease writing certain lines of insurance.

Amended by Laws 1986, c. 251, § 28, eff. Nov. 1, 1986.

§36-1805. Appointment of conservator; duties.

A. If, after notice and hearing, at the conclusion of the 90-day period the Commissioner determines that the insurer has failed to comply with his lawful requirements, or upon consent of the insurer, he may appoint a conservator, who shall immediately:

1. Take charge of such insurer and all of the property, books, records and effects;

2. Conduct its business; and

3. Take such other steps toward the removal of the causes and conditions which have necessitated such order, as the Commissioner may direct.

B. During the pendency of conservatorship, the conservator shall make such reports as may be required by the Commissioner, and may:

1. Take all necessary measures to preserve, protect and recover any assets or property of such insurer including claims or causes of action belonging to or which may be asserted by such insurer in his own name as conservator; and

2. File, prosecute and defend any legal actions which have been filed, or which may thereafter be filed, by or against such insurer, as he deems necessary to protect all of the interested parties or any property affected thereby. The conservator shall file all quarterly and annual reports required by the Oklahoma Insurance Code and in the same manner as the insurer.

C. If upon appointment of a conservator or at any time during the pendency of such conservatorship it appears that the insurer can best be protected by reinsuring the same, the conservator may, with the approval of the Commissioner, after appraisal of all assets of the insurer:

1. Reinsure all or part of such insurer's policies or certificates of insurance with any solvent insurers authorized to transact business in this state; and

2. To the extent that such insurer is possessed of reserves attributable to such policies or certificates of insurance, transfer to the reinsuring company such reserves or any portion thereof as may be required to consummate the reinsurance of such policies, which transfer of reserves shall not be deemed a preference of creditors.

D. If the Commissioner is satisfied that the insurer is not in condition to continue business in the interest of its policy or certificate holders, under the conservator, the Commissioner shall apply to the appropriate court for an order appointing him as receiver for the insurer, under the provisions of Article 18 of this

title. It shall be in the discretion of the Commissioner to determine whether or not he will operate the insurance company through a conservator, as provided above, or apply for an order appointing him receiver.

E. The cost incident to the supervisor's and conservator's service shall be fixed by the Commissioner and paid from the assets and funds of the insurer as the Commissioner may determine. The cost of the supervisor's or conservator's service must be reasonable under the circumstances and shall continue no longer than necessary to preserve the assets of the insurer, certificate holders and the policyholders. All legal work required under this act shall be performed by the Commissioner, his employees or special attorneys employed by the Commissioner. The cost of such attorneys' services must be reasonable under the circumstances and shall be paid from the assets and funds of the insurer to the Commissioner.

F. The supervision or conservation may continue until the Commissioner (1) feels certain that the insurer has corrected any deficiencies that caused the supervision or conservation, or (2) a receivership has been granted by the Court.

Amended by Laws 1985, c. 328, § 13, emerg. eff. July 29, 1985.

§36-1806. Limitation on appointments.

A. The Insurance Commissioner is hereby prohibited from appointing as supervisor or conservator during any period of supervision or conservatorship:

1. Any current or former officer, director, or employee of the insurer; and

2. Any person who is related to the Commissioner within the third degree of consanguinity or affinity.

B. The Commissioner is hereby prohibited from appointing as attorney for the insurer during any period of supervision or conservatorship:

1. Any current or former officer, director, or employee of the insurer; and

2. Any person who is related to the Commissioner within the third degree of consanguinity or affinity.

Laws 1975, c. 316, § 6, emerg. eff. June 12, 1975. Amended by Laws 2000, c. 197, § 1, eff. Nov. 1, 2000.

§36-1807. Foreign or alien insurers.

A. In the event that the Commissioner makes any of the findings provided for in Section 3 of this act concerning any foreign or alien insurer or finds that any such insurer is not possessed of the minimum surplus or capital required by the Insurance Code of this state for similar type domestic companies, or if a conservator, rehabilitator, receiver or liquidator has been appointed in the state of domicile, or if the insurer gives its consent, the

Commissioner shall have the same power and jurisdiction to appoint a supervisor or conservator as to the assets of such insurer located in this state as provided herein for domestic insurance companies.

B. In the event that any such insurer shall fail to comply with the provisions of Section 4 of this act with respect to any of its assets or policies located within this state during any 90-day period of supervision, such act or violation shall constitute sufficient grounds for the immediate revocation of its certificate of authority to do business in this state and for the immediate appointment of a conservator to take charge of its assets located within this state.

C. Any supervisor or conservator appointed with respect to assets located in this state belonging to a foreign or alien insurer shall have all of the power and authority provided for in Section 5 of this act with respect to such assets located in this state and, in addition, may reinsure all or any part of such insurer's policyholders or certificate holders located within this state with insurers authorized to transact business in this state and may transfer to the reinsuring company, as reserve funds, assets or any portion thereof in his possession as may be required to consummate the reinsurance of such policies and any of such assets transferred as reserve funds shall not be deemed a preference of creditors. Laws 1975, c. 316, § 7, emerg. eff. June 12, 1975.

§36-1808. Review of actions.

During the period of supervision or conservatorship, the insurer may request the Commissioner to review an action taken or proposed to be taken by the supervisor or conservator, specifying wherein the action complained of is believed not to be in the best interest of the insurer, and such request shall stay the action specified pending review of such action by the Commissioner whose decision shall be final, subject to judicial review under the Administrative Procedures Act.

Laws 1975, c. 316, § 8, emerg. eff. June 12, 1975.

§36-1809. Venue.

A. Except for causes of action based upon terms of any insurance policy issued by an insurer placed in conservatorship, any action filed against such insurer or its conservator during such conservatorship shall be filed in district court of Oklahoma County, Oklahoma.

B. The conservator for such insurer may file suit in district court of Oklahoma County, Oklahoma, against any person for the purpose of preserving, protecting or recovering any assets or property of such insurer, including claims or causes of action belonging to or which may be asserted by such insurer.

C. Nothing in this act shall be construed as authorizing the staying of litigation against the insurer.
Laws 1975, c. 316, § 9, emerg. eff. June 12, 1975.

§36-1810. Rehabilitation.

A conservator shall serve for such time as is necessary to accomplish the purposes of conservatorship under this act. If rehabilitated, the insurer shall be returned to the management or new management under such conditions as determined by the Commissioner.

Laws 1975, c. 316, § 10, emerg. eff. June 12, 1975.

§36-1811. Proceedings.

If the Commissioner decides to proceed under this act, the sequence of steps and proceedings shall be as set forth herein. In regard to insurer delinquencies or suspected delinquencies, however, the Commissioner may proceed and administer either under this act or under any other applicable law, or both.

Laws 1975, c. 316, § 11, emerg. eff. June 12, 1975.

§36-1812. Repealed by Laws 1997, c. 418, § 125, eff. Nov. 1, 1997.

§36-1901. Definitions.

For the purpose of Article 19 of the Oklahoma Insurance Code:

1. "Impairment" or "insolvency" means the capital of a stock insurer, or limited stock life, accident and health insurer, the net assets of a Lloyds association, or the surplus of a mutual or reciprocal insurer, shall be deemed to be impaired and the insurer shall be deemed to be insolvent, when such insurer shall not be possessed of assets at least equal to all liabilities and required reserves together with its total issued and outstanding capital stock if a stock insurer, the net assets if a Lloyds association, or the minimum surplus if a mutual or reciprocal insurer required by this Code to be maintained for the kind or kinds of insurance it is then authorized to transact;

2. "Insurer" means any person, firm, corporation, health maintenance organizations, association or aggregation of persons doing an insurance business and subject to the insurance supervisory authority of, or to liquidation, rehabilitation, reorganization or conservation by the Insurance Commissioner or the equivalent insurance supervisory official of another state;

3. "Delinquency proceeding" means any proceeding commenced against an insurer pursuant to this article for the purpose of liquidating, rehabilitating, reorganizing or conserving such insurer;

4. "State" means any state of the United States and also the District of Columbia and Puerto Rico;

5. "Foreign country" means territory not in any state;

6. "Domiciliary state" means the state in which an insurer is incorporated or organized, or in the case of an insurer incorporated or organized in a foreign country, the state in which such insurer, having become authorized to do business in such state, has at the commencement of delinquency proceedings, the largest amount of its assets held in trust and assets held on deposit for the benefit of its policyholders or policyholders and creditors in the United States, and any such insurer is deemed to be domiciled in such state;

7. "Ancillary state" means any state other than a domiciliary state;

8. "Reciprocal state" means any state other than this state that has enacted a law that sets forth a scheme for the administration of an insurer in receivership by the state's insurance commissioner or comparable insurance regulatory official;

9. "General assets" means all property, real, personal or otherwise, not specifically mortgaged, pledged, deposited or otherwise encumbered for the security or benefit of specified persons or a limited class or classes of persons, and as to such specifically encumbered property the term includes all such property or its proceeds in excess of the amount necessary to discharge the sum or sums secured thereby. Assets held in trust and assets held on deposit for the security or benefit of all policyholders or all policyholders and creditors in the United States shall be deemed general assets;

10. "Preferred claim" means any claim with respect to which the law of the state or of the United States accords priority of payments from the general assets of the insurer;

11. "Special deposit claim" means any claim secured by a deposit made pursuant to statute for the security or benefit of a limited class or classes of persons, but not including any general assets;

12. "Secured claim" means any claim secured by mortgage, trust deed, pledge, deposit as security, escrow, or otherwise, but not including special deposit claim or claims against general assets. The term also includes claims which more than four (4) months prior to the commencement of delinquency proceedings in the state of the insurer's domicile have become liens upon specific assets by reason of judicial process;

13. "Receiver" means receiver, liquidator, rehabilitator, or conservator as the context may require; and

14. "Qualified financial contract" means a commodity contract, forward contract, repurchase agreement, securities contract, swap agreement, and any similar agreement the Commissioner determines by rule, regulation, resolution, or order to be a qualified financial contract.

Added by Laws 1957, p. 293, § 1801, operative July 1, 1957.
Renumbered from § 1801 of this title by Laws 1975, c. 316, § 12,
emerg. eff. June 12, 1975. Amended by Laws 2003, c. 197, § 57, eff.
Nov. 1, 2003; Laws 2022, c. 119, § 2, eff. Nov. 1, 2022; Laws 2023,
c. 371, § 1, eff. Nov. 1, 2023.

§36-1902. Delinquency proceedings - Jurisdiction - Arbitration -
Venue - Appeal.

A. The district court is vested with exclusive original jurisdiction of delinquency proceedings pursuant to the provisions of this article, and is authorized to make all necessary and proper orders to carry out the purposes of this article.

B. Except as to claims against the estate, nothing in this article shall deprive a party in interest of any contractual right to pursue arbitration of any dispute under any law. Where an insurer subject to this article is a party to an arbitration proceeding, the venue of such arbitration proceeding shall be in Oklahoma County.

C. In addition to grounds otherwise provided by law, the following persons are subject to the personal jurisdiction of the district court:

1. Current and former agents and brokers of the insurer;
2. Policy holders and reinsurers of the insurer;
3. Current and former officers, directors, managers, trustees, organizers, promoters, and any other persons in control of the insurer; and
4. Any third party administrator for an insurer and any person that maintains information for an insurer.

D. Notwithstanding any other provision in this article, this section shall not confer jurisdiction on the district court to resolve coverage disputes between guaranty associations and those asserting claims against an association resulting from the initiation of a delinquency proceeding under this article except to the extent that the guaranty association has otherwise expressly consented to such jurisdiction pursuant to a plan of rehabilitation or liquidation that resolves its obligations to covered policyholders.

E. The determination of any dispute with respect to the statutory obligations of any guaranty association by a court or administrative agency or body with jurisdiction in the state of domicile of the guaranty association shall be binding and conclusive as to the parties in a delinquency proceeding initiated in the district court, including, without limitation, the policyholders of the insurer.

F. The venue of delinquency proceedings against any insurer shall be in Oklahoma County.

G. No person other than the Insurance Commissioner, his attorney, or the Attorney General representing the Insurance Commissioner shall appear in the courts of this state requesting the appointment of a receiver or otherwise commence delinquency proceedings to take over, liquidate, rehabilitate, reorganize, or conserve an insurer and no court shall entertain a petition for the commencement of such proceedings unless the same has been filed in the name of the state on the relation of the Insurance Commissioner.

H. An appeal shall lie to the Supreme Court from an order granting or refusing rehabilitation, liquidation, or conservation, and from every other order in delinquency proceedings having the character of a final order as to the particular portion of the proceedings embraced therein.

Added by laws 1957, p. 294, § 1802. Renumbered from § 1802 of this title by Laws 1975, c. 316, § 12, emerg. eff. June 12, 1975.

Amended by Laws 1983, c. 68, § 11, eff. Nov. 1, 1983; Laws 1999, c. 333, § 2, eff. July 1, 1999.

§36-1903. Commencement of delinquency proceedings.

The Insurance Commissioner shall commence any such proceeding, his attorney or the Attorney General representing him, by an application to the court for an order directing the insurer to show cause why the Insurance Commissioner should not have the relief prayed for. On the return of such order to show cause, and after a full hearing, the court shall either deny the application or grant the application, together with such other relief as the nature of the case and the interests of policyholders, creditors, stockholders, members, subscribers, or the public may require. Laws 1957, p. 294, § 1803; Laws 1975, c. 316, § 12, emerg. eff. June 12, 1975.

§36-1904. Injunctions.

A. Upon application by the Insurance Commissioner for such an order to show cause, or at any time thereafter, the court may without notice issue an injunction restraining the insurer, its officers, directors, stockholders, members, subscribers, agents and all other persons for the transaction of its business or the waste or disposition of its property until the further order of the court. Notwithstanding the foregoing, or any other provision of this chapter, no Federal Home Loan Bank shall be stayed, enjoined, or prohibited from exercising or enforcing any right or cause of action regarding collateral pledged under any security agreement, or any pledge, security, collateral or guarantee agreement or any other similar arrangement or credit enhancement relating to such Federal Home Loan Bank security agreement.

B. The court may at any time during a proceeding under this article issue such other injunctions or orders as may be deemed

necessary to prevent interference with the Insurance Commissioner or the proceedings, or waste of the assets of the insurer, or the commencement or prosecution of any actions, or the obtaining of preferences, judgments, attachments or other liens, or the making of any levy against the insurer or against its assets or any part thereof.

C. Notwithstanding any other provision of law, no bond shall be required of the Insurance Commissioner as a prerequisite for the issuance of any injunction or restraining order pursuant to this section.

D. Nothing in this section shall deprive a party in interest of any contractual right to pursue arbitration of any dispute under any law, and venue shall be as provided in subsection B of Section 1902 of this title.

Added by Laws 1957, p. 294, § 1804, operative July 1, 1957.

Renumbered from § 1804 of this title by Laws 1975, c. 316, § 12, emerg. eff. June 12, 1975. Amended by Laws 1999, c. 333, § 3, eff. July 1, 1999; Laws 2013, c. 113, § 1, emerg. eff. April 22, 2013.

§36-1905. Grounds for rehabilitation of domestic insurers.

The Insurance Commissioner may apply to the court for an order appointing the Commissioner as receiver of and directing the Commissioner to rehabilitate a domestic insurer upon one or more of the following grounds. That the insurer:

1. Is impaired or insolvent.
2. Is in a condition such that the continued operation would be hazardous to the policyholders, the creditors of the insurer, or the general public.
3. Has refused to submit its books, records, accounts or affairs to reasonable examination by the Insurance Commissioner.
4. Has failed to comply with an order of the Insurance Commissioner to make good an impairment of capital or surplus or both.
5. Has transferred or attempted to transfer substantially its entire property or business, or has entered into any transaction the effect of which is to merge substantially its entire property or business in that of any other insurer without having first obtained the written approval of the Insurance Commissioner.
6. Has willfully violated its charter or any law of this state.
7. Has an officer, director, or manager who has refused to be examined under oath concerning its affairs, for which purpose the Insurance Commissioner is hereby authorized to conduct and to enforce by all appropriate and available means any such examination under oath in any other state or territory of the United States, in which any such officer, director, or manager may then presently be, to the full extent permitted by the laws of such other state or territory, this special authorization considered.

8. Has been the subject of an application for the appointment of a receiver, trustee, custodian, or sequestrator of the insurer or its property otherwise pursuant to the provisions of this code, but only if such appointment has been made or is imminent and its effect is or would be to oust the courts of this state of jurisdiction hereunder.

9. Has consented to such an order through a majority of its directors, stockholders, members or subscribers.

10. Has failed to pay a final judgment rendered against it in this state upon any insurance contract issued or assumed by it, within thirty (30) days after the judgment became final or within thirty (30) days after the time for taking an appeal has expired, or within thirty (30) days after dismissal of an appeal before final termination, whichever date is the later.

Added by Laws 1957, p. 295, § 1805. Renumbered from § 1805 of this title by Laws 1975, c. 316, § 12, emerg. eff. June 12, 1975.

Amended by Laws 2001, c. 363, § 15, eff. July 1, 2001.

§36-1906. Grounds for liquidation.

The Insurance Commissioner may apply to the court for an order appointing the Commissioner as receiver (if the appointment of the Commissioner as receiver shall not be then in effect) and directing the Commissioner to liquidate the business of a domestic insurer, foreign or of the United States branch of an alien insurer having trusted assets in this State, regardless of whether or not there has been a prior order directing the Commissioner to rehabilitate such insurer, upon any grounds specified in Section 1905 of this title, or if such insurer:

1. Has ceased transacting business for a period of one (1) year, or

2. Is an insolvent insurer and has commenced voluntary liquidation or dissolution, or attempts to commence or prosecute any action or proceeding to liquidate its business or affairs, or to dissolve its corporate charter, or to procure the appointment of a receiver, trustee, custodian, or sequestrator under any law except this Code.

3. Has failed, if a domestic insurer, to obtain from the Insurance Commissioner a certificate of authority to transact a business of insurance in Oklahoma for one of the immediately preceding five (5) years.

Added by Laws 1957, p. 295, § 1806. Renumbered from § 1806 of this title by Laws 1967, c. 212, § 1, emerg. eff. May 1, 1967. Amended by Laws 1975, c. 316, § 12, emerg. eff. June 12, 1975; Laws 2001, c. 363, § 16, eff. July 1, 2001.

§36-1907. Grounds for conservation of foreign insurers.

The Insurance Commissioner may apply to the court for an order appointing him as receiver or ancillary receiver, and directing him to conserve the assets within this state of a foreign insurer upon any of the following grounds:

1. Upon any of the grounds specified in sections 1805 or 1806 of this article, or

2. Upon the ground that its property has been sequestered in its domiciliary sovereignty or in any other sovereignty.

Laws 1957, p. 295, § 1807; Laws 1975, c. 316, § 12, emerg. eff. June 12, 1975.

§36-1908. Grounds for conservation of alien insurers.

The Insurance Commissioner may apply to the court for an order appointing him as receiver or ancillary receiver, and directing him to conserve the assets within this state of any alien insurer upon any of the following grounds:

1. Upon any of the grounds specified in sections 1805 or 1806 of this article.

2. Upon the ground that the insurer has failed to comply, within the time designated by the Insurance Commissioner, with an order made by him to make good an impairment of its trusteed funds, or

3. Upon the ground that the property of the insurer has been sequestered in its domiciliary sovereignty or elsewhere.

Laws 1957, p. 295, § 1808; Laws 1975, c. 316, § 12, emerg. eff. June 12, 1975.

§36-1909. Grounds for ancillary liquidation of foreign insurers.

The Insurance Commissioner may apply to the court for an order appointing him as ancillary receiver of and directing him to liquidate the business of a foreign insurer having assets, business, or claims in this state upon the appointment in the domiciliary state of such insurer of a receiver, liquidator, conservator, rehabilitator or other officer by whatever name called for the purpose of liquidating the business of such insurer.

Laws 1957, p. 296, § 1809; Laws 1975, c. 316, § 12, emerg. eff. June 12, 1975.

§36-1910. Order of rehabilitation; termination.

A. An order to rehabilitate a domestic insurer shall direct the Insurance Commissioner forthwith to take possession of the property of the insurer and to conduct the business thereof, and to take such steps toward removal of the causes and conditions which have made rehabilitation necessary as the court may direct.

B. If at any time the Insurance Commissioner deems that further efforts to rehabilitate the insurer would be useless, he may apply to the court for an order of liquidation.

C. The Insurance Commissioner, or any interested person upon due notice to the Insurance Commissioner, at any time may apply to the court for an order terminating the rehabilitation proceedings and permitting the insurer to resume possession of its property and the conduct of its business, but no such order shall be granted except when, after a full hearing, the court has determined that the purposes of the proceeding have been fully accomplished.
Added by Laws 1957, p. 296, § 1810. Renumbered from Title 36, § 1810 by Laws 1975, c. 316, § 12, emerg. eff. June 12, 1975.

§36-1911. Order of liquidation of domestic insurers.

A. An order to liquidate the business of a domestic insurer shall direct the Insurance Commissioner forthwith to take possession of the property of the insurer, to liquidate its business, to deal with the insurer's property and business in his own name as Insurance Commissioner or in the name of the insurer, as the court may direct, and to give notice to all creditors who may have claims against the insurer to present such claims.

B. The Insurance Commissioner may apply for and secure an order dissolving the corporate existence of a domestic insurer upon his application for an order of liquidation of such insurer or at any time after such order has been granted.
Laws 1957, p. 296, § 1811; Laws 1975, c. 316, § 12, emerg. eff. June 12, 1975.

§36-1912. Order of liquidation of alien insurers.

An order to liquidate the business of a United States branch of an alien insurer having trusteed assets in this state shall be in the same terms as those prescribed for domestic insurers, save and except only that the assets of the business of such United States branch shall be the only assets included therein.
Laws 1957, p. 296, § 1812; Laws 1975, c. 316, § 12, emerg. eff. June 12, 1975.

§36-1913. Order of conservation or ancillary liquidation of foreign or alien insurers.

A. An order to conserve the assets of a foreign or alien insurer shall require the Insurance Commissioner forthwith to take possession of the property of the insurer within this state and to conserve it, subject to the further direction of the court.

B. An order to liquidate the assets in this state of a foreign insurer shall require the Insurance Commissioner forthwith to take possession of the property of the insurer within this state and to liquidate it subject to the orders of the court and with due regard to the rights and powers of the domiciliary receiver, as provided in this article.

Laws 1957, p. 296, § 1813; Laws 1975, c. 316, § 12, emerg. eff. June 12, 1975.

§36-1914. Conduct of delinquency proceedings against domestic and alien insurers - Limitations on power of Commissioner - Conflict of interest.

A. Whenever under this article of this title a receiver is to be appointed in delinquency proceedings for a domestic or alien insurer, the court shall appoint the Insurance Commissioner as the receiver. The court shall order the Insurance Commissioner forthwith to take possession of the assets of the insurer and to administer the same under the orders of the court.

B. As domiciliary receiver, the Insurance Commissioner shall be vested by operation of law with the title to all of the property, contracts, and rights of action and all of the books and records of the insurer, wherever located, as of the date of entry of the order directing the Commissioner to rehabilitate or liquidate a domestic insurer or to liquidate the United States branch of an alien insurer domiciled in this state, and the Commissioner shall have the right to recover the same and reduce the same to possession; except that ancillary receivers in reciprocal states shall have, as to assets located in their respective states, the rights and powers which are herein prescribed for ancillary receivers appointed in this state as to assets located in this state.

C. The recording of a certified copy of the order directing possession to be taken in the office of the county clerk of the county where the proceedings are pending shall impart the same notice as would be imparted by a deed, bill of sale, or other evidence of title duly recorded or filed.

D. The Insurance Commissioner as domiciliary receiver shall be responsible for the proper administration of all assets coming into the Commissioner's possession or control. The court may at any time require a bond from the Commissioner or any assistants or deputies if deemed desirable for the protection of the assets.

E. Upon taking possession of the assets of an insurer, the domiciliary receiver shall, subject to the direction of the court, immediately proceed to conduct the business of the insurer or to take such steps as are authorized by this article for the purpose of rehabilitating, liquidating, or conserving the affairs or assets of the insurer.

F. 1. In connection with delinquency proceedings, the Insurance Commissioner may appoint one or more assistant commissioners to act for the Commissioner and may employ such counsel, clerks, and assistants as are deemed necessary. The compensation of the assistant commissioners, counsel, clerks, or deputies and all expenses of taking possession of the insurer and of conducting the proceedings shall be fixed by the receiver, subject

to the approval of the court, and shall be paid out of the funds or assets of the insurer. Within the limits of duties imposed upon them, assistant commissioners shall possess all the powers given to the receiver and, in the exercise of those powers, shall be subject to all of the duties, powers, and limitations imposed upon the receiver with respect to such proceedings.

2. The Commissioner, as receiver, is prohibited from appointing any person who is related to the Commissioner within the third degree of consanguinity or affinity. Any appointment in violation of this paragraph is void.

3. The Commissioner, as receiver, is prohibited from entering into any contract with any person who is related to the Commissioner within the third degree of consanguinity or affinity. Any contract in violation of this paragraph is void.

Added by Laws 1957, p. 296, § 1814. Renumbered from § 1814 of this title by Laws 1975, c. 316, § 12, emerg. eff. June 12, 1975.

Amended by Laws 2000, c. 197, § 2, eff. Nov. 1, 2000.

§36-1915. Conduct of delinquency proceedings against foreign insurers.

A. Whenever under this article an ancillary receiver is to be appointed in delinquency proceedings for an insurer not domiciled in this state, the court shall appoint the Insurance Commissioner as ancillary receiver. The Insurance Commissioner shall file a petition requesting the appointment on the grounds set forth in section 1809 of this article (1) if he finds that there are sufficient assets of the insurer located in this state to justify the appointment of an ancillary receiver, or (2) if ten (10) or more persons resident in this state having claims against such insurer file a petition with the Insurance Commissioner requesting the appointment of such ancillary receiver.

B. The domiciliary receiver for the purpose of liquidating an insurer domiciled in a reciprocal state shall be vested by operation of law with the title to all of the property, contracts, and rights of action and all of the books and records of the insurer located in this state, and he shall have the immediate right to recover balances due from local agents and to obtain possession of any books and records of the insurer found in this state. He shall also be entitled to recover the other assets of the insurer located in this state, except that upon the appointment of an ancillary receiver in this state, the ancillary receiver shall during the ancillary receivership proceedings have the sole right to recover such other assets. The ancillary receiver shall, as soon as practicable, liquidate from their respective securities those special deposit claims and secured claims which are proved and allowed in the ancillary proceedings in this state, and shall pay the necessary expense of the proceedings. All remaining assets he shall promptly

transfer to the domiciliary receiver. Subject to the foregoing provisions, the ancillary receiver and his deputies shall have the same powers and be subject to the same duties with respect to the administration of such assets as a receiver of an insurer domiciled in this state.

C. The domiciliary receiver of an insurer domiciled in a reciprocal state may sue in this state to recover any assets of such insurer to which he may be entitled under the laws of this state. Laws 1957, p. 297, § 1815; Laws 1975, c. 316, § 12, emerg. eff. June 12, 1975.

§36-1916. Claims of nonresidents against domestic insurers.

A. In a delinquency proceeding begun in this state against a domestic insurer, claimants residing in reciprocal states may file claims either with the ancillary receivers, if any, in their respective states, or with the domiciliary receiver. All such claims must be filed on or before the last date fixed for the filing of claims in the domiciliary delinquency proceedings.

B. Controverted claims belonging to claimants residing in reciprocal states may either (1) be proved in this state, or (2) if ancillary proceedings have been commenced in such reciprocal states, may be proved in those proceedings. In the event a claimant elects to prove his claim in ancillary proceedings, if notice of the claim and opportunity to appear and be heard is afforded the domiciliary receiver of this state as provided in section 1817 of this article with respect to ancillary proceedings in this state, the final allowance of such claim by the court in the ancillary state shall be accepted in this state as conclusive as to its amount and shall also be accepted as conclusive as to its priority, if any, against special deposits or other security located within the ancillary state.

Laws 1957, p. 298, § 1816; Laws 1975, c. 316, § 12, emerg. eff. June 12, 1975.

§36-1917. Claims against foreign insurers.

A. In a delinquency proceeding in a reciprocal state against an insurer domiciled in that state, claimants against such insurer who reside within this state may file claims either with the ancillary receiver, if any, appointed in this state, or with the domiciliary receiver. All such claims must be filed on or before the last date fixed for the filing of claims in the domiciliary delinquency proceedings.

B. Controverted claims belonging to claimants residing in this state may either (1) be proved in the domiciliary state as provided by the law of that state, or (2) if ancillary proceedings have been commenced in this state, be approved in those proceedings. In the event that any such claimant elects to prove his claim in this

state, he shall file his claim with the ancillary receiver and shall give notice in writing to the receiver in the domiciliary state, either by registered mail or by personal service at least forty days prior to the date set for hearing. The notice shall contain a concise statement of the amount of the claim, the facts on which the claim is based, and the priorities asserted, if any. If the domiciliary receiver within thirty (30) days after the giving of such notice shall give notice in writing to the ancillary receiver and to the claimant, either by registered mail or by personal service, of his intention to contest such claim, he shall be entitled to appear or to be represented in any proceeding in this state involving adjudication of the claim. The final allowance of the claim by the courts of this state shall be accepted as conclusive as to its amount and shall also be accepted as conclusive as to its priority, if any, against special deposits or other security located within this state.

Laws 1957, p. 298, § 1817; Laws 1975, c. 316, § 12, emerg. eff. June 12, 1975.

§36-1918. Proof of claims; notice; hearing.

A. All claims against an insurer against which delinquency proceedings have been begun shall set forth in reasonable detail the amount of the claim, or the basis upon which such amount can be ascertained, the facts upon which the claim is based, and the priorities asserted, if any. All such claims shall be signed by the claimant, or someone authorized to act on his or her behalf, and shall be supported by such documents as may be material thereto. Claimant shall, in the time and manner set forth by the receiver, fully comply with any and all requests by the receiver for claimant to provide information or evidence supplementary to that required in this article, including, but not limited to, testimony under oath, affidavits, and depositions.

B. All claims filed in this state shall be filed with the receiver, whether domiciliary or ancillary, in this state, on or before the last date for filing as specified by the court.

C. Within such period as the court may fix, the receiver shall report the claim to the court, specifying in such report a recommendation with respect to the action to be taken thereon. Upon receipt of such report, the court shall fix a time for hearing the claim and shall direct that the claimant or the receiver, as the court shall specify, shall give such notice as the court shall determine to such persons as shall appear to the court to be interested therein. All such notices shall specify the time and place of the hearing and shall concisely state the amount and nature of the claim, the priorities asserted, if any, and the recommendation of the receiver with reference thereto.

D. At the hearing, all persons interested shall be entitled to appear and the court shall enter an order allowing, allowing in part, or disallowing the claim. Any such order shall be deemed to be an appealable order.

Laws 1957, p. 298, § 1818; Laws 1975, c. 316, § 12, emerg. eff. June 12, 1975; Laws 2022, c. 119, § 3, eff. Nov. 1, 2022.

§36-1919. Priority of certain claims.

A. In a delinquency proceeding against an insurer domiciled in this state, claims owing to residents of ancillary states shall be preferred claims if like claims are preferred under the laws of this state. All such claims owing to residents or nonresidents shall be given equal priority of payment from general assets regardless of where such assets are located.

B. In a delinquency proceeding against an insurer domiciled in a reciprocal state, claims owing to residents of this state shall be preferred if like claims are preferred by the laws of that state.

C. The owners of special deposit claims against an insurer for which a receiver is appointed in this or any other state shall be given priority against their several special deposits in accordance with the provisions of the statutes governing the creation and maintenance of such deposits. If there is a deficiency in any such deposit so that the claims secured thereby are not fully discharged therefrom, the claimants may share in the general assets, but such sharing shall be deferred until general creditors, and also claimants against other special deposits who have received smaller percentages from their respective special deposits, have been paid percentages of their claims equal to the percentage paid from the special deposit.

D. The owner of a secured claim against an insurer for which a receiver has been appointed in this or any other state may surrender his security and file his claim as a general creditor, or the claim may be discharged by resort to the security, in which case the deficiency, if any, shall be treated as a claim against the general assets of the insurer on the same basis as claims of unsecured creditors. If the amount of the deficiency has been adjudicated in ancillary proceedings as provided in this article or if it has been adjudicated by a court of competent jurisdiction in proceedings in which the domiciliary receiver has had notice and opportunity to be heard, such amounts shall be conclusive; otherwise the amount shall be determined in the delinquency proceeding in the domiciliary state.

Laws 1957, p. 299, § 1819; Laws 1975, c. 316, § 12, emerg. eff. June 12, 1975.

§36-1920. Attachment and garnishment of assets.

During the pendency of delinquency proceedings in this or any reciprocal state, no action or proceedings in the nature of an attachment, garnishment or execution shall be commenced or maintained in the courts of this state against the delinquent insurer or its assets. Any lien obtained by any such action or proceeding within four (4) months prior to the commencement of any such delinquency proceeding or at any time thereafter shall be void as against any rights arising in such delinquency proceeding. Laws 1957, p. 299, § 1820; Laws 1975, c. 316, § 12, emerg. eff. June 12, 1975.

§36-1921. Uniform insurers liquidation act.

A. Paragraphs 1 to 13, inclusive, of section 1801 of this article, together with sections 1803, 1804, 1814 to 1820, inclusive, of this article constitute and may be referred to as the uniform insurers liquidation act.

B. The uniform insurers liquidation act shall be so interpreted and construed as to effectuate its general purpose to make uniform the law of those states that enact it. To the extent that its provisions when applicable conflict with other provisions of this article the provisions of such act shall control.

Laws 1957, p. 299, § 1821; Laws 1975, c. 316, § 12, emerg. eff. June 12, 1975.

§36-1922. Power and authority of the receiver.

A. The receiver shall have the power:

1. To hold hearings, to subpoena witnesses for the purpose of compelling their attendance, to administer oaths, to examine any person under oath, and to compel any persons to subscribe to their testimony after it has been correctly reduced to writing; and in connection therewith to require the production of any books, papers, records, data or other documents, electronic or paper, that the receiver deems relevant to the inquiry;

2. To audit the books and records of all agents of the insurer, including, but not limited to, third-party administrators, and affiliated and nonaffiliated management companies insofar as those records relate to the business activities of the insurer;

3. To conduct litigation, including:

- a. to continue to prosecute or defend, and to institute in the name of the insurer or in the receiver's own name, suits or other legal proceedings, in this state or elsewhere,
- b. to abandon the prosecution of claims the receiver deems unprofitable to pursue further,
- c. to collect all debts and monies due and claims belonging to the insurer, wherever located, and in furtherance of this purpose to institute action in

- this or other jurisdictions in order to forestall garnishment and attachment proceedings against those debts, including the power to sell, compound, compromise or assign debts for purposes of collection upon such terms and conditions as the receiver deems consistent with the purpose of the Uniform Insurers Liquidation Act, and pursue any creditor's remedies available to enforce the insurer's claims,
- d. to assert all defenses available to the insurer as against third persons, including statutes of limitation, statutes of frauds and the defense of usury. A waiver of any defense by the insurer after a petition for supervision, conservation, receivership, rehabilitation or liquidation has been filed shall not bind the receiver. Whenever a guaranty association has an obligation to defend any suit, the receiver shall defer to that obligation and may defend only in cooperation with the guaranty association or in the absence of the guaranty association's defense,
 - e. to exercise and enforce all the rights, remedies and powers of any creditor, shareholder, policyholder or member, including any power to avoid any transfer, transaction or lien that may be avoidable under the Uniform Insurers Liquidation Act or otherwise, and
 - f. to intervene in any proceeding wherever instituted that might lead to the appointment of a receiver or trustee for the insurer or any of its property, and to act as the receiver or trustee whenever the appointment is offered.

The receiver shall have exclusive standing in any action that may exist to assert claims or defenses on behalf of the creditors, members, policyholders or shareholders of the insurer or the public against any person, except to the extent that a claim is personal to a specific creditor, member, policyholder or shareholder and recovery on the claim would not inure to the benefit of the estate. If the receiver sells or dissolves the corporate entity or charter of the insurer, the receiver shall have the power to apply to any court in this state or elsewhere for leave to substitute the receiver for the insurer as a party. This paragraph does not infringe or impair any of the rights provided to a guaranty association pursuant to its enabling statute or otherwise;

- 4. a. To conduct public or private sales of the insurer's property, and thereby to acquire, hypothecate, encumber, lease, sell, improve, transfer, abandon or otherwise dispose of or deal with any property of the insurer at its market value or upon such terms and conditions as are fair and reasonable, and to settle

or resolve any claim or lawsuit brought by the receiver on behalf of the insurer or pending when a petition for supervision, conservation, receivership, rehabilitation or liquidation is filed, or commute or settle any claim of reinsurance under any contract of reinsurance,

- b. to transfer either proceeds of or rights to payment under ceding reinsurance agreements covering policies to a third-party transferee. A transfer of rights to payment shall only be made with the consent of the reinsurer and in conjunction with the transfer to such person of all rights and obligations relating to the transferred ceding reinsurance agreement and of all property, including any guarantees or other credit enhancement, securing any claims of each party under each reinsurance agreement. The consent of a reinsurer under this subparagraph shall not be unreasonably withheld. If the receiver believes that the consent of a reinsurer was unreasonably withheld, the receiver may petition the receivership court to order binding arbitration. The arbitration shall be conducted in accordance with the arbitration procedures in the reinsurance contract, or if no such provisions exist, in accordance with the procedures of the American Arbitration Association. A transferee under this subparagraph shall have the rights to collect and enforce collection of the reinsurance for the amount payable to the ceding insurer or to its receiver, without diminution because of the insolvency or because the receiver has failed to pay all or a portion of the claim. The transfer of these rights shall not give rise to any defense regarding the reinsurer's obligations under the reinsurance agreement regardless of whether the agreement or other applicable law prohibits the transfer of rights under the reinsurance agreement. Except as provided in this subparagraph, any transfer of rights pursuant to this provision shall not impair any rights or defenses of the reinsurer that existed prior to the transfer or would have existed in the absence of the transfer. Except as otherwise provided in this subparagraph, any transfer of rights pursuant to this provision shall not relieve the transferee or the receiver from obligations owed to the reinsurer pursuant to the reinsurance or other agreement, and
- c. to execute, acknowledge and deliver any deeds, assignments, releases and other instruments necessary

or proper to effectuate any sale of property or other transaction in connection with the liquidation or rehabilitation and to file any necessary documents for record in the office of any recorder of deeds or record office in this state or elsewhere where property of the insurer is located;

5. a. To use property of the estate to transfer policy obligations to a solvent assuming insurer, if the transfer can be arranged without prejudice to applicable priorities under Section 1927.1 of this title,
- b. to use property of the estate to transfer the insurer's obligations under surety bonds and surety undertakings, and collateral held by the insurer with respect to the reimbursement obligations of the principals under those surety bonds and surety undertakings, to a solvent assuming insurer, if the transfer can be arranged without prejudice to applicable priorities under Section 1927.1 of this title; and if the receivership court so orders, the estate shall have no further liability under the transferred policies, surety bonds, or surety undertakings after the transfer is made, and
- c. upon the issuance of an order of liquidation and a finding of insolvency, policies or portions of policies of life, disability income, long-term care or health insurance or annuities covered by one or more guaranty associations, under applicable law, shall continue in force, subject to the terms of the policy, including any terms restructured pursuant to a court-approved rehabilitation plan, to the extent necessary to permit the guaranty associations to discharge their statutory obligations. Policies or portions of policies of life, disability income, long-term care or health insurance or annuities, not covered by one or more guaranty associations, and other types of policies, shall terminate by operation of law, except to the extent the receiver proposes and the receivership court approves the use of property of the estate, consistent with subparagraphs a and b of this paragraph, for the purpose of continuing the contracts or coverage by transferring them to an assuming reinsurer;

6. To borrow money on the security of the property of the estate or without security and to execute and deliver all documents necessary to that transaction for the purpose of facilitating the liquidation or rehabilitation. Any such funds borrowed may be

repaid as an administrative expense and have priority over any other claims in Class 1 under the priority of distribution in Section 1927.1 of this title;

7. To enter into contracts, and to assume or reject any executory contract or unexpired lease to which the insurer is a party; provided, however, if the receiver is bound by any provision of any contract of or by the insurer which requires arbitration, such arbitration shall be conducted in the State of Oklahoma; notwithstanding the foregoing, or any other provision of this chapter, no receiver shall have the power to reject, disavow or repudiate any Federal Home Loan Bank security agreement, or any pledge, security, collateral or guarantee agreement or any other similar arrangement or credit enhancement relating to such Federal Home Loan Bank security agreement;

8. To take possession of the records and property of the insurer. Guaranty associations shall have reasonable access to the records of the insurer necessary for them to carry out their statutory obligations;

9. To deposit in one or more banks in this state sums required for meeting current administration expenses and dividend distributions;

10. To invest the assets of the estate;

11. To enter into agreements with any receivers or commissioners of any other states; and

12. To exercise all powers now held or hereafter conferred upon receivers by the applicable statutory and common law of this state not inconsistent with the provisions of the Uniform Insurers Liquidation Act.

B. The receiver is vested with all the rights of the entity or entities in receivership.

C. The enumeration, in this section, of the powers and authority of the receiver shall not be construed as a limitation upon the receiver, nor shall it exclude in any manner the right to do other acts not specifically enumerated or otherwise provided for, to the extent necessary or appropriate for the accomplishment of or in aid of the purpose of liquidation or rehabilitation.

D. The receiver shall not be obligated to defend any action against the insurer or insured. An insured not defended by a guaranty association may provide his or her own defense, and include the cost of the defense as part of any claim of the insured against the estate, if the defense was an obligation of the insurer. The right of the receiver to contest coverage on a particular claim shall be deemed preserved without the necessity of an express reservation of rights.

Added by Laws 1957, p. 300, § 1822, operative July 1, 1957.

Renumbered from Title 36, § 1822 by Laws 1975, c. 316, § 12, emerg. eff. June 12, 1975. Amended by Laws 2008, c. 184, § 17, eff. July

1, 2008; Laws 2008, c. 353, § 1, eff. Nov. 1, 2008; Laws 2013, c. 113, § 2, emerg. eff. April 22, 2013.

§36-1923. Exemption of Commissioner from fees.

The Insurance Commissioner shall not be required to pay any fee to any public officer in this state for filing, recording, issuing a transcript or certificate or authenticating any paper or instrument pertaining to the exercise by the Insurance Commissioner of any of the powers or duties conferred upon him under this article, whether or not such paper or instrument be executed by the Insurance Commissioner or his assistants, deputies, employees or attorneys of record and whether or not it is connected with the commencement of any action or proceeding by or against the Insurance Commissioner, or with the subsequent conduct of such action or proceeding. Laws 1957, p. 300, § 1823; Laws 1975, c. 316, § 12, emerg. eff. June 12, 1975.

§36-1924. Repealed by Laws 2008, c. 184, § 32, eff. July 1, 2008.

§36-1924.1. Limitation on actions.

A. If applicable statutory or common law, an order, or an agreement fixes, defines, extends or tolls a period within which the insurer may commence an action, and this period has not expired before the date of the filing of the initial petition in a delinquency proceeding as defined in Section 1901 of Title 36 of the Oklahoma Statutes, the receiver shall not by reason thereof be barred from commencing such an action if the receiver does so on or before the later of:

1. The end of the period, including any suspension of the period occurring on or after the filing of the initial petition in a delinquency proceeding; or

2. Four (4) years after the entry of the order commencing a delinquency proceeding or entry of a subsequent order granting a different form of relief in a delinquency proceeding.

B. Except as provided in subsection A of this section, if applicable law, an order or an agreement fixes, defines, extends or tolls a period within which the insurer may file any pleading, demand, notice, or proof of claim or loss, or cure a default in a case or proceeding, or perform any other similar act, and the period has not expired before the date of the filing of the initial petition in a delinquency proceeding, the receiver shall not by reason thereof be barred from filing, curing or performing, as the case may be, if the receiver does so on or before the later of:

1. The end of the period, including any suspension of the period occurring on or after the filing of the initial petition in a delinquency proceeding; or

2. One hundred eighty (180) days after the entry of the order granting the initial petition in the delinquency proceeding, or within such further extension thereof granted by the court which is shown to the satisfaction of the court not to be unfairly prejudicial to the other party.

C. If applicable law, an order or an agreement fixes, defines, extends or tolls a period for commencing or continuing a civil action in a court other than the receivership court on a claim against the insurer, and the period has not expired before the date of the filing of the initial petition in a delinquency proceeding, then the period does not expire until the later of:

1. The end of the period, including any suspension of the period occurring on or after the filing of the initial petition in a delinquency proceeding; or

2. Thirty (30) days after termination or expiration of a court ordered stay with respect to the claim.

D. An allegation by the receiver of improper or fraudulent conduct against any person shall not be the basis of a defense to the enforcement of a contractual obligation owed to the insurer by a third party, but the third party is not barred by this section from seeking to establish independently as a defense that the conduct was materially and substantially related to the contractual obligation for which enforcement is sought.

E. No prior wrongful or negligent actions of any present or former officer, manager, director, trustee, owner, employee or agent of the insurer may be asserted as a defense to a claim by the receiver under a theory of estoppel, comparative fault, intervening cause, proximate cause, reliance, mitigation of damages or otherwise; except that the affirmative defense of fraud in the inducement may be asserted against the receiver in a claim based on a contract and a principal under a surety bond or a surety undertaking shall be entitled to credit against any reimbursement obligation to the receiver for the value of any property pledged to secure the reimbursement obligation to the extent that the receiver has possession or control of the property or the insurer or its agents misappropriated such property. Evidence of fraud in the inducement will be admissible only if it is contained in the records of the insurer.

F. No action or inaction by the insurance regulatory authorities may be asserted as a defense to a claim by the receiver.

G. A judgment or order entered against an insured or the insurer in contravention of any stay or injunction under the Uniform Insurers Liquidation Act, or at any time by default or collusion, shall not be considered as evidence of liability or of the quantum of damages in adjudicating claims filed in the estate arising out of the subject matter of the judgment or order.

H. The provisions of subsection G of this section do not apply to guaranty associations' claims for amounts paid on settlements and judgments in pursuit of their statutory obligations.
Added by Laws 2008, c. 184, § 18, eff. July 1, 2008.

§36-1925. Rights and liabilities fixed as of date liquidation order filed.

The rights and liabilities of the insurer and of its creditors, policyholders, stockholders, members, subscribers, and all other persons interested in its estate shall, unless otherwise directed by the court, be fixed as of the date on which the order directing the liquidation of the insurer is filed in the office of the clerk of the court which made the order, subject to the provisions of this article with respect to the rights of claimants holding contingent claims.

Laws 1957, p. 300, § 1825; Laws 1975, c. 316, § 12, emerg. eff. June 12, 1975.

§36-1926. Fraudulent transfers or transactions - Avoidance.

A. Every transfer made or suffered to be made and every obligation incurred by an insurer within one (1) year prior to the filing of a successful petition for rehabilitation or liquidation under the Insurance Code is fraudulent as to then existing and future creditors if made or incurred without fair consideration or with actual intent to hinder, delay or defraud either existing or future creditors. A transfer made or an obligation incurred by an insurer ordered to be rehabilitated or liquidated under the Insurance Code, which is fraudulent under this section, may be avoided by the receiver, except as to a person who in good faith is a purchaser, lienor, or obligee for a present fair equivalent value, and except that any purchaser, lienor or obligee, who in good faith has given a consideration less than fair for such transfer, lien, or obligation, may retain the property, lien or obligation as security for repayment. The court may, on due notice, order any such transfer or obligation to be preserved for the benefit of the estate, and in that event, the receiver shall succeed to and may enforce the rights of the purchaser, lienor, or obligee.

B. Every director, officer, employee, stockholder, member, agent, subscriber, and any other person acting on behalf of such insurer who shall be concerned in any such act or deed and every person receiving thereby any property of such insurer or the benefit thereof shall be personally liable therefor and shall be bound to account to the Insurance Commissioner.

C. The Insurance Commissioner as receiver in any proceeding under this article may avoid any transfer of or lien upon the property of an insurer which any creditor, stockholder, subscriber or member of such insurer might have avoided and may recover the

property so transferred unless such person was a bona fide holder for value prior to the date of the granting of an order to show cause under this article. Such property or its value may be recovered from anyone who has received it except a bona fide holder for value as herein specified.

D. Any transaction of the insurer with a reinsurer shall be deemed fraudulent and may be avoided by the receiver under this section if:

1. The transaction consists of the termination, adjustment or settlement of a reinsurance contract in which the reinsurer is released from any part of its duty to pay the originally specified share of losses that had occurred prior to the time of the transactions, unless the reinsurer gives a present fair equivalent value for the release; and

2. Any part of the transaction took place within one (1) year prior to the date of filing of the petition through which the receivership was commenced.

E. Notwithstanding subsection A of this section, or any other provision of this chapter, no receiver shall avoid any transfer of, or any obligation to transfer, money or any other property arising under or in connection with any Federal Home Loan Bank security agreement, or any pledge, security, collateral or guarantee agreement or any other similar arrangement or credit enhancement relating to such Federal Home Loan Bank security agreement. However, a transfer may be avoided under this section if it was made with actual intent to hinder, delay or defraud either existing or future creditors.

Added by Laws 1957, p. 300, § 1826, operative July 1, 1957.

Renumbered from § 1804 of this title by Laws 1975, c. 316, § 12, emerg. eff. June 12, 1975. Amended by Laws 1990, c. 297, § 3, eff. Sept. 1, 1990; Laws 2013, c. 113, § 3, emerg. eff. April 22, 2013.

§36-1926.1. Netting agreements or qualified financial contracts – Contractual rights – Termination – Transfer.

A. As used in this section:

1. "Actual direct compensatory damages" means normal and reasonable costs of cover or other reasonable measures of damages utilized in the derivatives, securities, or other market for the contract and agreement claims. Provided, actual direct compensatory damages shall not include punitive or exemplary damages, damages for lost profit or lost opportunity, or damages for pain and suffering;

2. "Business day" means a day other than a Saturday, Sunday, or any day on which either the New York Stock Exchange or the Federal Reserve Bank of New York is closed;

3. "Contractual right" means any right set forth in a rule or bylaw of a derivatives clearing organization, a multilateral clearing organization, a national securities exchange, a national

securities association, a securities clearing agency, a contract market designated under the federal Commodity Exchange Act, a derivatives transaction execution facility registered under the federal Commodity Exchange Act, or a board of trade or in a resolution of the governing board thereof and any right, whether or not evidenced in writing, arising under statutory or common law, or under law merchant, or by reason of normal business practice; and

4. "Walkaway clause" means a provision in a netting agreement or a qualified financial contract which, after calculation of a value of a party's position or an amount due to or from one of the parties in accordance with its terms upon termination, liquidation, or acceleration of the netting agreement or qualified financial contract, either does not create a payment obligation of a party or extinguishes a payment obligation of a party in whole or in part solely because of the party's status as a non-defaulting party.

B. Notwithstanding any other provision of the Oklahoma Insurance Code, including any other provision permitting the modification of contracts, no person or entity shall be stayed or prohibited from exercising:

1. A contractual right to cause termination, liquidation, acceleration, or closeout of obligations under or in connection with any netting agreement or qualified financial contract with an insurer because of:

- a. the insolvency, financial condition, or default of the insurer at any time, provided the right is enforceable under applicable law other than the provisions of this act, or
- b. the commencement of a formal delinquency proceeding under the provisions of this section;

2. Any right under a pledge, security, collateral, reimbursement, guarantee agreement or arrangement, any other similar security agreement or arrangement, or other credit enhancement relating to one or more netting agreements or qualified financial contracts;

3. Subject to any provision of Section 1928 of Title 36 of the Oklahoma Statutes, any right to set off or net out any termination value, payment amount, or other transfer obligation arising under or in connection with one or more qualified financial contracts where the counterparty or its guarantor is organized under the laws of the United States or a state or a foreign jurisdiction approved by the Securities Valuation Office (SVO) of the National Association of Insurance Commissioners (NAIC) as eligible for netting; or

4. If a counterparty to a master netting agreement or a qualified financial contract with an insurer subject to a proceeding under this section terminates, liquidates, closes out, or accelerates the agreement or contract, damages shall be measured as of the date or dates of termination, liquidation, closeout, or

acceleration. The amount of a claim for damages shall be actual direct compensatory damages calculated in accordance with subsection G of this section.

C. 1. Upon termination of a netting agreement or qualified financial contract, the net or settlement amount, if any, owed by a non-defaulting party to an insurer against which an application or petition has been filed under this section shall be transferred to or on the order of the receiver for the insurer, even if the insurer is the defaulting party, notwithstanding any walkaway clause in the netting agreement or qualified financial contract.

2. Any limited two-way payment or first method provision in a netting agreement or qualified financial contract with an insurer which has defaulted shall be deemed to be a full two-way payment or second method provision as against the defaulting insurer. Any such property or amount shall, except to the extent it is subject to one or more secondary liens or encumbrances or rights of netting or setoff, be a general asset of the insurer.

D. In making any transfer of a netting agreement or qualified financial contract of an insurer subject to a proceeding under this section, the receiver shall either:

1. Transfer to one party, other than an insurer subject to a proceeding under this section, all netting agreements and qualified financial contracts between a counterparty or any affiliate of the counterparty and the insurer which is the subject of the proceeding, including:

- a. all rights and obligations of each party under each netting agreement and qualified financial contract, and
- b. all property, including any guarantees or other credit enhancement, securing any claims of each party under each netting agreement and qualified financial contract; or

2. Transfer none of the netting agreements, qualified financial contracts, rights, obligations, or property referred to in paragraph 1 of this subsection, with respect to the counterparty and any affiliate of the counterparty.

E. If a receiver for an insurer makes a transfer of one or more netting agreements or qualified financial contracts, then the receiver shall use its best efforts to notify any person who is party to the netting agreements or qualified financial contracts of the transfer by twelve o'clock p.m. on the business day following the transfer.

F. Notwithstanding any other provision of the Oklahoma Insurance Code, a receiver shall not avoid a transfer of money or other property arising under or in connection with a netting agreement, qualified financial contract, or any pledge, security, collateral or guarantee agreement, or any other similar security

arrangement or credit support document relating to a netting agreement or qualified financial contract which is made before the commencement of a formal delinquency proceeding under this Code. Provided, however, a transfer may be avoided under Section 1926 of Title 36 of the Oklahoma Statutes if the transfer was made with actual intent to hinder, delay, or defraud the insurer, a receiver appointed for the insurer, or existing or future creditors.

G. 1. In exercising the rights of disaffirmance or repudiation of a receiver with respect to any netting agreement or qualified financial contract to which an insurer is a party, the receiver for the insurer shall either:

- a. disaffirm or repudiate all netting agreements and qualified financial contracts between a counterparty or any affiliate of the counterparty and the insurer which is the subject of the proceeding, or
- b. disaffirm or repudiate none of the netting agreements and qualified financial contracts referred to in subparagraph a of this paragraph with respect to the person or any affiliate of the person or entity.

2. Notwithstanding any other provision of this Code, any claim of a counterparty against the estate arising from the receiver's disaffirmance or repudiation of a netting agreement or qualified financial contract which has not been previously affirmed in the liquidation or immediately preceding a conservation or rehabilitation case shall be determined and shall be allowed or disallowed as if the claim had arisen before the date of the filing of the petition for liquidation or, if a conservation or rehabilitation proceeding is converted to a liquidation proceeding, as if the claim had arisen before the date of the filing of the petition for conservation or rehabilitation. The amount of the claim shall be the actual direct compensatory damages determined as of the date of the disaffirmance or repudiation of the netting agreement or qualified financial contract.

H. The provisions of this section shall not apply to persons or entities who are affiliates of the insurer which is the subject of the proceeding.

I. All rights of counterparties under this Code shall apply to netting agreements and qualified financial contracts entered into on behalf of the general account or separate accounts if the assets of each separate account are available only to counterparties to netting agreements and qualified financial contracts entered into on behalf of the separate account.

Added by Laws 2023, c. 371, § 2, eff. Nov. 1, 2023.

§36-1927. Repealed by Laws 1996, c. 246, § 25, eff. July 1, 1996.

§36-1927.1. Priority of distribution of claims from insurer's estate.

A. The priority of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is set forth in this section. Before the members of the next class receive any payment, every claim in each class shall be:

1. Paid in full; or
2. Protected by adequate funds retained for such payment.

Once such funds are approved by the court and paid or retained by the liquidator, the insurer's estate shall have no further liability to members of that class except to the extent of the retained funds and any other undistributed funds. Payment of retained funds pursuant to court order under this section extinguishes the potential liability of the receiver to the United States or any other governmental entity. No subclasses shall be established within any class except as otherwise provided by law. No claim by a shareholder, policyholder or other creditor shall be permitted to circumvent the priority classes through the use of equitable remedies. The order of distribution of claims shall be as provided in subsection B of this section.

B. 1. Class 1. The reasonable costs and expenses of administration expressly approved by the receiver, including but not limited to the following:

- a. the actual and necessary costs of preserving or recovering the assets of the insurer,
- b. compensation for all authorized services rendered in the conservation, rehabilitation or liquidation,
- c. any necessary filing or recordation fees,
- d. the fees and mileage payable to witnesses, including experts, and other litigation costs and expenses,
- e. authorized reasonable attorney fees and other professional services rendered in the conservation, rehabilitation or liquidation, and
- f. any reasonable expenses that were incurred in furtherance of activities that provided a material economic benefit to the estate.

2. Class 2. The administrative expenses of guaranty associations. For purposes of this section these expenses shall be the reasonable expenses incurred by guaranty associations where the expenses are not payments or expenses which are required to be incurred as direct policy benefits in fulfillment of the terms of the insurance contract or policy, and that are of the type and nature that, but for the activities of the guaranty association otherwise would have been incurred by the receiver, including but not limited to evaluations of policy coverage, activities involved in the adjustment and settlement of claims under policies, including those of in-house or outside adjusters, and the reasonable expenses

incurred in connection with the arrangements for ongoing coverage through transfer to other insurers, policy exchanges or maintaining policies in force. The receiver may in his or her sole discretion approve as an administrative expense under this section any other reasonable expenses of the guaranty association if the receiver finds:

- a. the expenses are not expenses required to be paid or incurred as direct policy benefits by the terms of the policy, and
- b. the expenses were incurred in furtherance of activities that provided a material economic benefit to the estate as a whole, irrespective of whether the activities resulted in additional benefits to covered claimants.

The court shall approve such expenses unless it finds the receiver abused his or her discretion in approving the expenses. If the receiver determines that any administrative expenses of a guaranty association were not reasonable expenses, but were nevertheless paid out of a statutory deposit or the proceeds of any bond or other asset located in another state or foreign country, then the court shall adjudge the Class 3 claims of that association to have been paid to the extent of the amount of unreasonable expenses thus paid from those assets.

If the receiver determines that the assets of the estate will be sufficient to pay all Class 1 claims in full, Class 2 claims shall be paid, provided that the liquidator shall secure from each of the associations receiving disbursements pursuant to this section an agreement to return to the liquidator such disbursements, together with investment income actually earned on such disbursements, as may be required to pay Class 1 claims. No bond shall be required of any such association.

3. Class 3. All claims under policies including claims of the federal or any state or local government for losses incurred ("loss claims") including third-party claims, claims for unearned premiums, all claims of a guaranty association for payment of covered claims or covered obligations of the insurer and all claims of a guaranty association for reasonable expenses other than those included in Class 2. All claims under life and health insurance and annuity policies, whether for death proceeds, health benefits, annuity proceeds, or investment values shall be treated as loss claims. That portion of any loss, indemnification for which is provided by other benefits or advantages recovered by the claimant, shall not be included in this class, other than benefits or advantages recovered or recoverable in discharge of familial obligation of support or by way of succession at death or as proceeds of life insurance, or as gratuities. No payment by an employer to his employee shall be treated as a gratuity.

Notwithstanding the foregoing, the following claims shall be excluded from Class 3 priority:

- a. obligations of the insolvent insurer arising out of reinsurance contracts,
- b. obligations incurred after the expiration date of the insurance policy or after the policy has been replaced by the insured or canceled at the insured's request or after the policy has been canceled as provided in this act. Notwithstanding the provisions of this paragraph, earned premium claims on policies, other than reinsurance agreements, shall not be excluded,
- c. obligations to insurers, insurance pools or underwriting associations and their claims for contribution, indemnity or subrogation, equitable or otherwise,
- d. any claim which is in excess of any applicable limits provided in the insurance policy issued by the insolvent insurer,
- e. any amount accrued as punitive or exemplary damages unless expressly covered under the terms of the policy, and
- f. tort claims of any kind against the insurer, and claims against the insurer for bad faith or wrongful settlement practices.

4. Class 4. Claims of the federal government other than those claims included in Class 3.

5. Class 5. Debts due employees for services, benefits, contractual or otherwise due arising out of such reasonable compensation to employees for services performed to the extent that they do not exceed two (2) months of monetary compensation and represent payment for services performed within six (6) months before the filing of the petition for liquidation or, if rehabilitation preceded liquidation, within one (1) year before the filing of the petition for rehabilitation. Principal officers and directors shall not be entitled to the benefit of this priority except as otherwise approved by the liquidator and the court. This priority shall be in lieu of any other similar priority which may be authorized by law as to wages or compensation of employees.

6. Class 6. Claims of any person, including claims of state or local governments, except those specifically classified elsewhere in this section.

7. Class 7. Claims for commissions and service fees, and claims of attorneys for fees and expenses owed them by a person for services rendered in opposing a formal delinquency proceeding. In order to prove the claim, the claimant must show that the insurer which is the subject of the delinquency proceeding incurred such fees and expenses based on its best knowledge, information and

belief, formed after reasonable inquiry indicating opposition was in the best interests of the person, was well grounded in fact and was warranted by existing law or a good-faith argument for the extension, modification or reversal of existing law, and that opposition was not pursued for any improper purpose, such as to harass or to cause unnecessary delay or needless increase in the cost of the litigation.

8. Class 8. Claims of any state or local government for a penalty or forfeiture, but only to the extent of the pecuniary loss sustained from the act, transaction or proceeding out of which the penalty or forfeiture arose, with reasonable and actual costs occasioned thereby. The remainder of such claims shall be postponed to the class of claims under paragraph 9 of this subsection.

9. Class 9. Surplus or contribution notes or similar obligations, premium refunds on assessable policies, interest on claims of Classes 1 through 8 and any other claims specifically subordinated to this class.

10. Class 10.

a. Claims of shareholders or other owners arising out of their capacity as shareholders or other owners, or arising in any other capacity or facts except as they may be qualified in Class 3 or 4 above; provided, however, that no shareholder, member or other owner shall be entitled to, or receive, any distribution from the insolvent insurer's estate under this paragraph, if:

- (1) the intentional wrongdoing, fraud, gross negligence, negligence or other act, failure to act, transaction or proceeding of such shareholder, member or owner, alone or in concert with others, or of a director or officer of the insolvent insurer, is found by a court of competent jurisdiction or by the receiver in his or her reasonable discretion, to have caused, or to have been a contributing factor to, the insolvency of the insolvent insurer,
- (2) funds were collected from the shareholder, member or other owner, either directly or through an insurance carrier, fidelity bond issuer or other entity, as a consequence of, or related to, a claim made or brought by the receiver of said insurer, or
- (3) any of the funds available for distribution consist of punitive damages recovered by the receiver of said estate from any source based upon any claim made or brought by the receiver.

In the event there is no eligible shareholder, member or other owner entitled to distribution in accordance with this paragraph, the remaining funds and other property of the insolvent insurer's estate, if any, shall be distributed to a fund established and held in the name of, and for the use and benefit of, the receiver, through the Oklahoma Receivership Office or any similar entity established by the receiver, which shall be used in the administration of other insurers in rehabilitation or liquidation.

b. All funds distributed to the receiver under this paragraph shall be utilized by the receiver's staff engaged in the rehabilitation or liquidation of insolvent insurance business companies for the following purposes:

- (1) the administration of liquidations of estates which temporarily or permanently do not have the financial capability to administer the liquidation, including the prosecution of claims of the receiver, or
- (2) the prosecution of petitions to place insurers in rehabilitation or liquidation.

In the event such funds are distributed to or for an insolvent insurer, the receiver shall obtain from the insurer a promissory note or other evidence of indebtedness, secured by collateral if possible, for the amount distributed, which shall be treated as a Class 1 expense under paragraph 1 of this subsection. The receiver shall make good-faith efforts to collect reimbursement of any such loans. No funds distributed to the receiver under this paragraph shall be used to pay claims other than Class 1 claims under paragraph 1 of this subsection. The funds are not funds of the State of Oklahoma and are not funds of the Oklahoma Insurance Department or any other agency of the State of Oklahoma.

This paragraph shall apply to the administration of all receivership estates open and ongoing as of November 1, 2014, and to all receivership proceedings commenced after November 1, 2014.

C. If any claimant of this state, another state or foreign country shall be entitled to or shall receive a dividend upon his or her claim out of a statutory deposit or the proceeds of any bond or other asset located in another state or foreign country, unless such deposit or proceeds shall have been delivered to the domiciliary liquidator, then the claimants shall not be entitled to any further dividend from the receiver until and unless all other claimants of the same class, irrespective of residence or place of the acts or

contracts upon which their claims are based, shall have received an equal dividend upon their claims, and after such equalization, such claimants shall be entitled to share in the distribution of further dividends by the receiver, along with and like all other creditors of the same class, wheresoever residing.

D. Upon the declaration of a dividend, the receiver shall apply the amount of the dividend against any indebtedness owed to the insurer by the person entitled to the dividend. There shall be no claim allowed for any deductible charged by a guaranty association or entity performing a similar function.

E. This section shall apply to pending and future claims in existing delinquency proceedings as well as to claims in delinquency proceedings arising after the effective date of this section.

F. If any provision of this section or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or application of this section to the extent such other provisions or application can be given effect without the invalid provision or application.

Added by Laws 1996, c. 246, § 7, eff. July 1, 1996. Amended by Laws 1997, c. 418, § 90, eff. Nov. 1, 1997; Laws 2014, c. 386, § 1, eff. Nov. 1, 2014.

§36-1928. Offsets.

A. In all cases of mutual debts or mutual credits between the insurer and another person, whether arising out of one or more contracts between the insurer and another person, in connection with any action or proceeding under this article, such credits and debts shall be offset and the balance only shall be allowed or paid, except as provided in subsection B of this section.

B. No offset shall be allowed if:

1. The obligation of the insurer would not, at the date of the entry of any liquidation order or otherwise as provided in Section 1925 of this title, entitle the claimant to share in the assets of the insurer;

2. The obligation of the insurer was purchased by or transferred to the claimant to be used as an offset;

3. The obligation is to pay an assessment levied against the members of a mutual insurer, or against the subscribers of a reciprocal insurer, or to pay a balance upon the subscription to the capital stock of a stock insurer;

4. The obligation of the insurer is owed to an affiliate of such person, or any other entity or association other than the person;

5. The obligation of the person is owed to an affiliate of the insurer, or any other entity or association other than the insurer;
or

6. The obligation between the person and the insurer arises from business where either the person or the insurer has assumed risks and obligations from the other party and then has ceded back to that party substantially the same risks and obligations. Added by Laws 1957, p. 301, § 1828, operative July 1, 1957. Renumbered from § 1828 of this title by Laws 1975, c. 316, § 12, emerg. eff. June 12, 1975. Amended by Laws 1988, c. 252, § 2, eff. Nov. 1, 1988; Laws 1996, c. 246, § 8, eff. July 1, 1996; Laws 1997, c. 156, § 3, eff. Nov. 1, 1997; Laws 1999, c. 333, § 4, eff. July 1, 1999; Laws 2004, c. 274, § 11, eff. July 1, 2004.

§36-1929. Allowance of certain claims.

A. No contingent claim shall share in a distribution of the assets of an insurer which has been adjudicated to be insolvent by an order made pursuant to this article, except that such claim shall be considered, if properly presented, and may be allowed to share where:

1. Such claim becomes absolute against the insurer on or before the last day for filing proof of claims against the assets of such insurer, or

2. There is a surplus and the liquidation is thereafter conducted upon the basis that such insurer is solvent.

B. Where an insurer has been so adjudicated to be insolvent any person who has a cause of action against an insured of such insurer under a liability insurance policy issued by such insurer shall have the right to file a claim in the liquidation proceeding, regardless of the fact that such claim may be contingent, and such claim may be allowed:

1. If it may be reasonably inferred from the proof presented upon such claim that such person would be able to obtain a judgment upon such cause of action against such insured, and

2. If such person shall furnish suitable proof, unless the court for good cause shown shall otherwise direct, that no further valid claim against such insurer arising out of his cause of action other than those already presented can be made, and

3. If the total liability of such insurer to all claimants arising out of the same act of its insured shall be no greater than his maximum liability would be were it not in liquidation.

C. No judgment against such an insured taken after the date of entry of the liquidation order shall be considered in the liquidation proceedings as evidence of liability, or of the amount of damages, and no judgment against an insured taken by default or by collusion prior to the entry of the liquidation order shall be considered as conclusive evidence in the liquidation proceedings, either of the liability of such insured to such person upon such cause of action or of the amount of damages to which such person is therein entitled.

D. No claim of any secured claimant shall be allowed at a sum greater than the difference between the value of the claim without security and value of the security itself as of the date of the entry of the order of liquidation or such other date set by the court for determining rights and liabilities as provided in section 1825 of this article unless the claimant shall surrender his security to the Insurance Commissioner, in which event the claim shall be allowed in the full amount for which it is valued. Laws 1957, p. 301, § 1829; Laws 1975, c. 316, § 12, emerg. eff. June 12, 1975.

§36-1930. Time to file claims.

If upon commencement of delinquency proceedings under this article or at any time during the proceedings the insurer shall not be clearly solvent, the court shall, after such notice and hearing as it deems proper, make an order declaring the insurer to be insolvent. Thereupon, regardless of any prior notice which may have been given to creditors, the Insurance Commissioner shall notify all persons who may have claims against the insurer and who have not filed proper proofs thereof to present the same to the Commissioner, at a place specified in the notice, within four (4) months from the date of entry of the order, or within a longer time prescribed by the court not to exceed one hundred eighty (180) days which shall be specified in the notice. The notice shall be given in a manner determined by the court.

Only upon application of the liquidator, the receivership court may allow alternative procedures and requirements for the filing of proofs of claim or for allowing or proving claims. Upon application, if the court dispenses with the requirements of filing a proof of claim by a person, class, or group of persons, a proof of claim for such a person, class, or group shall be deemed as having been filed for all purposes, except that the receivership court's waiver of proof-of-claim requirements shall not impact a guaranty association's proof-of-claim filing requirement or coverage determinations to the extent that the guaranty fund statute or filing requirements are inconsistent with the court's waiver of proof.

Proofs of claim may be filed after the date specified in the notice, but no such claim shall share in the distribution of the assets until all allowed claims, proofs of which have been filed before that date, have been paid in full with interest. Added by Laws 1957, p. 302, § 1830. Renumbered from § 1830 of this title by Laws 1975, c. 316, § 12, emerg. eff. June 12, 1975. Amended by Laws 1996, c. 246, § 9, eff. July 1, 1996; Laws 2022, c. 119, § 4, eff. Nov. 1, 2022.

§36-1931. Report for assessment.

Within three (3) years from the date an order or rehabilitation or liquidation of a domestic mutual insurer or a domestic reciprocal insurer was filed in the office of the clerk of the court by which such order was made, the Insurance Commissioner may make a report to the court setting forth:

1. The reasonable value of the assets of the insurer,
 2. The insurer's probable liabilities, and
 3. The probable necessary assessment, if any, to pay all claims and expenses in full, including expenses of administration.
- Laws 1957, p. 302, § 1831; Laws 1975, c. 316, § 12, emerg. eff. June 12, 1975.

§36-1932. Levy of assessment.

A. Upon the basis of the report provided for in section 1831 of this article, including any amendments thereof, the court, ex parte, may levy one or more assessments against all members of such insurer who, as shown by the records of the insurer, were members (if a mutual insurer) or subscribers (if a reciprocal insurer) at any time within one (1) year prior to the date of issuance of the order to show cause under section 1803 of this article.

B. Such assessment or assessments shall cover the excess of the probable liabilities over the reasonable value of the assets, together with the estimated cost of collection and percentage of uncollectibility thereof. The total of all assessments against any member or subscriber with respect to any policy, whether levied pursuant to this article or pursuant to any other provision of this code, shall be for no greater amount than that specified in the policy or policies of the member or subscriber and as limited under this code, except that if the court finds that the policy was issued at a rate or premium below the minimum rate lawfully permitted for the risk insured, the court may determine the upper limit of such assessment upon the basis of such minimum rate.

C. No assessment shall be levied against any member or subscriber with respect to any nonassessable policy issued in accordance with this code.

Laws 1957, p. 302, § 1832; Laws 1975, c. 316, § 12, emerg. eff. June 12, 1975.

§36-1933. Order to pay assessment.

After levy of assessment as provided in section 1832 of this article, upon the filing of a further detailed report by the Insurance Commissioner the court shall issue an order directing each member (if a mutual insurer) or each subscriber (if a reciprocal insurer), if he shall not pay the amount assessed against him to the Insurance Commissioner on or before a day to be specified in the order, to show cause why he should not be held liable to pay such assessment, together with costs as provided in section 1835 of this

article, and to show cause why the Insurance Commissioner should not have judgment therefor.

Laws 1957, p. 302, § 1833; Laws 1975, c. 316, § 12, emerg. eff. June 12, 1975.

§36-1934. Publication and service of assessment order.

The Insurance Commissioner shall cause a notice of such assessment order, setting forth a brief summary of the contents of such order, to be (1) published in such manner as shall be directed by the court, and (2) enclosed in a sealed envelope, addressed and mailed postage prepaid, to each member or subscriber liable thereunder at his last-known address as it appears on the records of the insurer, at least twenty (20) days before the return day of the order to show cause provided for in section 1833 of this article. Laws 1957, p. 303, § 1834; Laws 1975, c. 316, § 12, emerg. eff. June 12, 1975.

§36-1935. Judgment upon the assessment.

A. Upon the return day of the order to show cause provided for in section 1833 of this article, if the member or subscriber does not appear and serve duly verified objections upon the Insurance Commissioner, the court shall make and order adjudging that such member or subscriber is liable for the amount of the assessment against him, together with costs, and that the Insurance Commissioner may have judgment against the member or subscriber therefor.

B. If, on such return day, the member or subscriber shall appear and serve duly verified objections upon the Insurance Commissioner, there shall be a full hearing before the court which, after such hearing, shall make such order as the facts shall warrant.

C. Any such order shall have the same force and effect, shall be entered and docketed and may be appealed from, as if it were a judgment in an original action brought in the court in which the proceeding is pending.

Laws 1957, p. 303, § 1835; Laws 1975, c. 316, § 12, emerg. eff. June 12, 1975.

§36-1936. Restrictions on insurers subject to delinquency proceedings.

No insurer that is subject to any delinquency proceeding, whether formal or informal, administrative or judicial, shall:

1. be released from such proceeding, unless such proceeding is converted into a judicial rehabilitation or liquidation proceeding;
2. be permitted to solicit or accept new business or request or accept the restoration of any suspended or revoked license or certificate of authority;

3. be returned to the control of its shareholders or private management; or

4. have any of its assets returned to the control of its shareholders or private management; until all payments of or on account of the insurer's contractual obligations by all guaranty associations, along with all expenses thereof and interest on all such payments and expenses, shall have been repaid to the guaranty associations or a plan of repayment by the insurer shall have been approved by the guaranty associations. Added by Laws 1987, c. 177, § 9, eff. Nov. 1, 1987.

§36-1937. Immunity or indemnity of receivers and employees.

A. For the purposes of this section the persons entitled to protection under this section are:

1. The receiver, assistant receiver, and retained counsel responsible for the conduct of a delinquency proceeding under Article 19 of the Insurance Code, including present and former receivers; and

2. Their employees meaning all present and former assistant receivers and attorneys for the receiver appointed by the Insurance Commissioner and all persons whom the Commissioner, assistant receiver or retained counsel have employed to assist in a delinquency proceeding under Article 19 of the Insurance Code. Attorneys, accountants, auditors and other professional persons or firms, who are retained by the receiver as independent contractors and their employees shall not be considered employees of the receiver for purposes of this section.

B. If any legal action is commenced against the receiver or any employee, whether against him personally or in his official capacity, alleging property damage, property loss, personal injury or other civil liability caused by or resulting from any alleged act, error or omission of the receiver or any employee arising out of or by reason of their duties or employment, the receiver and any employee shall be indemnified from the assets of the insurer for all expenses, attorneys' fees, judgments, settlements, decrees or amounts due and owing or paid in satisfaction of or incurred in the defense of such legal action unless it is determined upon a final adjudication on the merits that the alleged act, error or omission of the receiver or employee giving rise to the claim did not arise out of or by reason of his duties or employment, or was caused by intentional or willful and wanton misconduct.

1. Attorneys' fees and any and all related expenses incurred in defending a legal action for which immunity or indemnity is available under this section shall be paid from the assets of the insurer, as they are incurred, in advance of the final disposition of such action upon receipt of an undertaking by or on behalf of the receiver or employee to repay the attorneys' fees and expenses if it

shall ultimately be determined upon a final adjudication on the merits that the receiver or employee is not entitled to immunity or indemnity under this section.

2. Any indemnification for expense payments, judgments, settlements, decrees, attorneys' fees, surety bond premiums or other amounts paid or to be paid from the insurer's assets pursuant to this section shall be an administrative expense of the insurer.

3. In the event of any actual or threatened litigation against a receiver or any employee for which immunity or indemnity may be available under this section, a reasonable amount of funds which in the judgment of the Insurance Commissioner may be needed to provide immunity or indemnity shall be segregated and reserved from the assets of the insurer as security for the payment of indemnity until such time as all applicable statutes of limitation shall have run and all actual or threatened actions against the receiver or any employee have been completely and finally resolved, and all obligations of the insurer and the Commissioner under this section shall have been satisfied.

4. In lieu of segregation and reserving of funds, the Insurance Commissioner shall have the discretion to obtain a surety bond or make other arrangements which shall enable the Commissioner to fully secure the payment of all obligations under this section.

C. If any legal action against an employee for which indemnity may be available under this section is settled prior to final adjudication on the merits, the insurer must pay the settlement amount on behalf of the employee, or indemnify the employee for the settlement amount, unless the Insurance Commissioner determines:

1. That the claim did not arise out of or by reason of the employee's duties or employment; or
2. That the claim was caused by the intentional or willful and wanton misconduct of the employee.

D. In any legal action in which the receiver is a defendant, that portion of any settlement relating to the alleged act, error or omission of the receiver shall be subject to the approval of the court before which the delinquency proceeding is pending. The court shall not approve that portion of the settlement if it determines:

1. That the claim did not arise out of or by reason of the receiver's duties or employment; or
2. That the claim was caused by the intentional or willful and wanton misconduct of the receiver.

E. Nothing contained or implied in this section shall operate, or be construed or applied to deprive the receiver or any employee of any immunity, indemnity, benefits of law, rights or any defense otherwise available.

F. 1. No legal action shall lie against the receiver or any employee based in whole or in part on any alleged act, error or omission which took place prior to September 1, 1992, unless suit is

filed and valid service of process is obtained prior to September 1, 1993.

2. Subsections B, C, and D of this section shall apply to any suit which is pending on or filed after September 1, 1992, without regard to when the alleged act, error or omission took place. Added by Laws 1992, c. 178, § 20, eff. Sept. 1, 1992.

§36-1938. Delinquency proceedings - Procedures - Compensation of personnel.

A. Upon written notice to the receiver, a person shall be placed on the service list to receive notice of matters filed by the receiver. It shall be the responsibility of the person requesting notice to inform the receiver in writing of any changes to his or her address, or to request that his or her name be deleted from the service list. The receiver may require that the persons on the service list provide confirmation that they wish to remain on the service list. Any person who fails to confirm his or her intent to remain on the service list may be purged from the service list. Inclusion on the service list does not confer standing in the delinquency proceeding to raise, appear, or be heard on any issue.

B. Except as otherwise provided by this act, notice and hearing of any matter submitted by the receiver to the receivership court for approval under this act shall be conducted as follows:

1. The receiver shall file an application explaining the proposed action and the basis therefor. The receiver may include any evidence in support of the application. If the receiver determines that any documents supporting the application are confidential, the receiver may submit them to the receivership court under seal for in-camera inspection;

2. The receiver shall provide notice of the application to all persons on the service list and any other parties as determined by the receiver. Notice may be provided by first-class mail, postage paid, electronic mail, or facsimile transmission, at the receiver's discretion. For purposes of this section, notice is deemed to be given on the date that it is deposited with the U.S. Postmaster or transmitted, as applicable, to the last-known address as shown on the service list;

3. Any party in interest objecting to the application shall file an objection specifying the grounds therefor within fourteen (14) days or such longer time as the court may specify in the notice of the filing of the application and shall serve copies on the receiver and any other persons served with the application within the same time period. An objecting party shall have the burden of showing why the receivership court should not authorize the proposed action;

4. If no objection to the application is timely filed, the receivership court may enter an order approving the application

without a hearing or hold a hearing to determine if the receiver's application should be approved. The receiver may request that the receivership court enter an order or hold a hearing on an expedited basis; and

5. If an objection is timely filed, the receivership court may hold a hearing. If the receivership court approves the application and, upon a motion by the receiver, determines that the objection was frivolous or filed merely for delay or for other improper purpose, the receivership court shall order the objecting party to pay the receiver's reasonable costs and fees of defending the action.

C. In any proceeding commenced against an insurer pursuant to Article 18 by a judicial proceeding or Article 19 of this title for the purpose of liquidating, rehabilitating, reorganizing or conserving such insurer, hereinafter called delinquency proceeding, the compensation of personnel employed or retained to assist the Insurance Commissioner with the proceeding shall be approved by the court before the compensation may be paid. The Insurance Commissioner shall apply to the court for approval; provided, if any board or association is authorized by the Commissioner to provide assistance to the Commissioner, the board or association shall apply to the court.

D. Upon receiving the application for approval of compensation, the party responsible for the filing of the application shall cause notice in writing of the application, time to file objections, and hearing if there are objections, to be served upon the following persons not less than ten (10) days before the objection period expires:

1. The persons or firms requesting the compensation;
2. The Commissioner, if not the applicant; and
3. Ten persons, or such lesser number as there may be, who hold the largest number of shares in the insurance company involved in the delinquency proceeding, as indicated by the company's stock register as of the time that the company was placed under supervision pursuant to Section 1804 of this title or at the time that an application was filed with the court for the commencement of a delinquency proceeding pursuant to Section 1903 of this title. Said shareholders shall serve as representatives of the insurance company.

E. The notice shall state the time to file objections and place of the hearing if there are objections, the reasons for the hearing and the following rights of any party served with notice:

1. To appear in person at the hearing or to be represented by counsel;
2. To testify under oath, call witnesses to testify, and furnish documentary evidence, relevant to the determination of the compensation;

3. To cross-examine witnesses and have a reasonable opportunity to inspect all documentary evidence; and

4. To subpoena witnesses and compel the production of testimony and documents, relevant to the determination of the compensation. The person making service shall make an affidavit of such service and file the notice and affidavit with the court.

F. At the hearing, the court shall fully investigate the compensation of persons employed or retained to assist the Insurance Commissioner with the conduct of the delinquency proceeding. The court shall not approve the compensation until it has been made to appear to the satisfaction of the court, based upon competent evidence, that such compensation is justified.

Added by Laws 1978, c. 144, § 1. Amended by Laws 1997, c. 418, § 23, eff. Nov. 1, 1997. Renumbered from § 351 of this title by Laws 1997, c. 418, § 127, eff. Nov. 1, 1997; Laws 2022, c. 119, § 5, eff. Nov. 1, 2022.

§36-2001. Short title.

This act shall be known and may be cited as the Oklahoma Property and Casualty Insurance Guaranty Association Act. Laws 1980, c. 362, § 1, emerg. eff. June 27, 1980.

§36-2002. Purpose of act.

A. The purpose of the Oklahoma Property and Casualty Insurance Guaranty Association Act is to provide a mechanism for the payment of covered claims under certain insurance policies, to avoid excessive delay in payment, to avoid financial loss to claimants or policyholders because of the insolvency of an insurer, and to provide an association to assess the cost of protection among insurers.

B. The Oklahoma Property and Casualty Insurance Guaranty Association Act shall be construed to effect the purpose provided for in subsection A of this section which shall constitute an aid and guide to interpretation of the Oklahoma Property and Casualty Insurance Guaranty Association Act.

Added by Laws 1980, c. 362, § 2, emerg. eff. June 27, 1980. Amended by Laws 2010, c. 159, § 1, eff. Nov. 1, 2010.

§36-2003. Application of act.

The Oklahoma Property and Casualty Insurance Guaranty Association Act shall apply to all kinds of direct insurance, but shall not be applicable to the following:

1. Life, annuity, health, or disability insurance;
2. Ocean marine insurance;
3. Fidelity or surety bonds, or any other bonding obligations;

4. Title, as defined in Sections 702, 703, 705, 708 and 709 of this title, mortgage or financial guaranty insurance or other forms of insurance offering protection against investment risks;

5. Credit insurance, insurance of warranties or service contracts, annuities, vendors single interest insurance, collateral protection insurance; and

6. Any transaction or combination of transactions between a person, including affiliates of the person, and an insurer, including affiliates of the insurer, which involves the transfer of investment or credit risk unaccompanied by transfer of investment risk.

Added by Laws 1980, c. 362, § 3, emerg. eff. June 27, 1980. Amended by Laws 1985, c. 328, § 14, emerg. eff. July 29, 1985; Laws 1986, c. 251, § 29, eff. Nov. 1, 1986; Laws 1994, c. 22, § 4, eff. Sept. 1, 1994; Laws 2010, c. 159, § 2, eff. Nov. 1, 2010.

§36-2004. Definitions.

As used in the Oklahoma Property and Casualty Insurance Guaranty Association Act:

1. "Affiliate" means a person who directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with another person on December 31 of the year next preceding the date the insurer becomes an insolvent insurer;

2. "Association" means the Oklahoma Property and Casualty Insurance Guaranty Association as created in Section 2005 of this title;

3. "Assumed claims transaction" means:

- a. policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, pursuant to a plan, approved by a domestic commissioner of the assuming insurer, which transfers the direct policy obligations and future policy renewals from one insurer to another insurer, or
- b. an assumption reinsurance transaction in which all of the following have occurred:
 - (1) the insolvent insurer assumed, prior to the entry of a final order of liquidation, the claim or policy obligations of another insurer under the claims or policies,
 - (2) the assumption of the claim or policy obligations has been approved, if an approval is required, by the appropriate regulatory authorities, and
 - (3) as a result of the assumption, the claim or policy obligations became the direct obligations

of the insolvent insurer through novation of the claims or policies;

4. "Claimant" means any person instituting a covered claim; provided that no person who is an affiliate of the insolvent insurer may be a claimant;

5. "Commissioner" means the Insurance Commissioner of Oklahoma;

6. "Control" 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 other than a commercial contract for goods or nonmanagement services, 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 a 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;

7. "Covered claim" means:

- a. an unpaid claim, including one of unearned premiums, submitted by a claimant, which arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this act applies, if the insurer becomes an insolvent insurer after the effective date of this act and the policy was issued by the insurer, and:
 - (1) the claimant or insured is a resident of this state at the time of the insured event, provided that for entities other than an individual, the residence of a claimant or insured is the state in which its principal place of business is located at the time of the insured event, or
 - (2) the property from which the claim arises is permanently located in this state,
- b. "Covered claim" shall not include:
 - (1) any amount awarded as punitive or exemplary damages,
 - (2) any amount sought as a return of premium under any retrospective rating plan,
 - (3) any amount due any reinsurer, insurer, insurance pool, or underwriting association, health maintenance organization, hospital plan corporation, professional health service corporation or self-insurer as subrogation recoveries, reinsurance recoveries, contribution, indemnification or otherwise. No claim for any amount due any reinsurer, insurer, insurance pool, or underwriting association, health

maintenance organization, hospital plan corporation, professional health service corporation or self-insurer may be asserted against a person insured under a policy issued by an insolvent insurer other than to the extent the claim exceeds the association obligation limitations set for in Section 2007 of this title,

- (4) any claims excluded pursuant to Section 15 of this act due to the high net worth of an insured,
- (5) any first party claims by an insured that is an affiliate of the insolvent company,
- (6) any fee or other amount relating to goods or services sought by or on behalf of any attorney or other provider of goods and services retained by the insolvent insurer or an insured prior to the date it was determined to be insolvent,
- (7) any fee or other amount sought by or on behalf of any attorney or other provider of goods and services retained by any insured or claimant in connection with the assertion or prosecution of any claim, covered or otherwise, against the Association,
- (8) any claims for interest,
- (9) any claim filed with the association or a liquidator for protection afforded under the policy of the insured for incurred-but-not-reported losses, or
- (10) notwithstanding any other provision of this act or any other law to the contrary, a claim that is filed with the association on a date that is later than eighteen (18) months after the date of the order of liquidation or that is unknown and unreported as of said date; provided, however, that this shall not include any claim for workers' compensation benefits pursuant to Title 85A of the Oklahoma Statutes and the applicable rules of OAC Title 810;

8. "Insolvent insurer" means an insurer that is licensed to transact insurance in this state either at the time the policy was issued, when the obligation with respect to the covered claim was assumed under an assumed claims transaction, or when the insured event occurred and against whom a final order of liquidation has been entered after the effective date of this act with a finding of insolvency by a court of competent jurisdiction in the state of domicile of the insurer;

9. "Insured" means any named insured, any additional insured, any vendor, lessor or any other party identified as an insured under the policy;

10. a. "Member insurer" means any person who:

- (1) writes any kind of insurance to which the Oklahoma Property and Casualty Insurance Guaranty Association Act applies pursuant to Section 2003 of this title, including the exchange of reciprocal or inter-insurance contracts, and
- (2) is licensed to transact insurance in this state, except those insurers enumerated in Section 110 of this title or those insurers that are otherwise exempted by law or order of the Commissioner.

b. An insurer shall cease to be a member insurer effective on the day following the termination or expiration of its license to transact the kinds of insurance to which the Oklahoma Property and Casualty Insurance Guaranty Association Act applies; however, the insurer shall be liable as a member insurer for any and all obligations, including but not limited to obligations for assessments levied after the termination or expiration, which relate to any insurer that becomes an insolvent insurer prior to the termination or expiration of the license of the insurer;

11. "Net direct written premiums" means direct gross premiums written in this state on insurance policies to which this act applies, including but not limited to policy and membership fees, less the following amounts:

- a. return premiums,
- b. premiums on policies not taken, and
- c. dividends paid or credited to policyholders on direct business. "Net direct written premiums" does not include premiums on contracts between insurers or reinsurers;

12. "Novation" means that the assumed claim or policy obligations became the direct obligations of the insolvent insurer through consent of the policyholder and that thereafter the ceding insurer or entity initially obligated under the claims or policies is released by the policyholder from performing its claim or policy obligations. Consent shall be express and an implied novation shall not be allowed for the purposes, implementation and application of the Oklahoma Property and Casualty Insurance Guaranty Association Act;

13. "Person" means the individual or other entities as defined in Section 104 of this title;

14. "Receiver" means liquidator, rehabilitator, conservator or ancillary receiver, as the context requires; and

15. "Self-insurer" means a person who covers its liability through a qualified individual or group self-insurance program or any other formal program created for the specific purpose of covering liabilities typically covered by insurance.

Added by Laws 1980, c. 362, § 4, emerg. eff. June 27, 1980. Amended by Laws 1986, c. 251, § 30, emerg. eff. June 13, 1986; Laws 1988, c. 252, § 3, eff. Nov. 1, 1988; Laws 2010, c. 159, § 3, eff. Nov. 1, 2010; Laws 2021, c. 478, § 13, emerg. eff. May 12, 2021.

§36-2005. Creation - Administration - Accounts - Membership - Plan of operation.

A. There is hereby created a nonprofit, unincorporated legal entity to be known as the Oklahoma Property and Casualty Insurance Guaranty Association. For purposes of administration and assessment, the Association shall be divided into three separate accounts:

1. The workers' compensation insurance account;

2. The automobile insurance account; and

3. The account for all other insurance to which the Oklahoma Property and Casualty Insurance Guaranty Association Act applies.

B. All insurers defined as member insurers pursuant to Section 2004 of this title shall be and remain members of the Association as a condition of their authority to transact insurance in this state. The Association shall perform its functions under a plan of operation established and approved under the Oklahoma Property and Casualty Insurance Guaranty Association Act.

Added by Laws 1980, c. 362, § 5, emerg. eff. June 27, 1980. Amended by Laws 1982, c. 258, § 2, emerg. eff. May 14, 1982; Laws 2010, c. 159, § 4, eff. Nov. 1, 2010.

§36-2006. Board of directors - Membership - Term - Approval - Vacancies - Compensation.

A. The business and functions of the Oklahoma Property and Casualty Insurance Guaranty Association shall be managed and administered by a board of twelve (12) directors composed of domestic, foreign and alien insurers who are member insurers, including a minimum of two domestic insurers, and two insurance agents who shall serve as ex officio members. In determining candidates to fill the member insurer positions, the board shall consider whether all insurers are fairly represented, including workers' compensation insurers and other property and casualty insurers. One of the ex officio members shall be the Executive Director of the Independent Insurance Agents of Oklahoma, Inc.; the other ex officio member shall be a licensed, resident property and casualty insurance agent chosen by the Governor. Each member of the

board of directors shall designate a full-time salaried employee to represent it on the board of directors. Each member except for the ex officio members shall serve for a term of two (2) years. The ex officio member who is appointed by the Governor shall serve at the pleasure of the Governor. Each appointed member insurer representative may designate an alternate representative to represent the insurer at any meeting of the board. Any person serving as an alternate representative shall, while serving, have all the powers and responsibilities of the appointed insurer representative. The members of the board of directors except for the ex officio members shall be subject to approval by the Insurance Commissioner. Vacancies on the board except for the ex officio members shall be filled for the remaining period of the term by a majority vote of the remaining board members, subject to the approval of the Commissioner.

B. In approving selections to the board, the Commissioner shall consider, among other things, whether all member insurers are fairly represented.

C. Members of the board shall serve without compensation but may be reimbursed from the assets of the Association for expenses incurred by them as members of the board of directors.
Added by Laws 1980, c. 362, § 6, emerg. eff. June 27, 1980. Amended by Laws 1985, c. 328, § 15, emerg. eff. July 29, 1985; Laws 2010, c. 159, § 5, eff. Nov. 1, 2010; Laws 2014, c. 78, § 1, eff. Nov. 1, 2014; Laws 2021, c. 478, § 14, emerg. eff. May 12, 2021.

§36-2007. Powers and duties of Association.

A. The Oklahoma Property and Casualty Insurance Guaranty Association shall:

1. Be obligated to pay the covered claims existing prior to the determination of insolvency if the claims arise within thirty (30) days after the determination of insolvency, or before the policy expiration date if less than thirty (30) days after the determination, or before the insured replaces the policy or causes its cancellation, if the insured does so within thirty (30) days of the determination. The obligation shall be satisfied by paying to the claimant an amount as follows:

- a. the full amount of a covered claim for benefits under a workers' compensation insurance coverage,
- b. an amount not exceeding Ten Thousand Dollars (\$10,000.00) per policy for a covered claim for the return of unearned premium, and
- c. an amount not exceeding One Hundred Fifty Thousand Dollars (\$150,000.00) per claimant for all other covered claims.

In no event shall the Association be obligated to pay a claimant an amount in excess of the obligation of the insolvent insurer under

the policy or coverage from which the claim arises or in excess of the limits of the obligation of the Association existing on the date on which the order of liquidation is filed with the court clerk;

2. Any obligation of the association to defend an insured shall cease upon the payment or tender by the association of an amount equal to the lesser of the covered claim obligation limit of the association or the applicable policy limit;

3. As payor of last resort, have all rights, duties and obligations of the insolvent insurer as if the insurer had not become insolvent including, but not limited to, the right to pursue and retain salvage and subrogation recoverable on covered claim obligations to the extent paid by the association. The association shall not be deemed the insolvent insurer for the purpose of conferring jurisdiction;

4. Allocate claims paid and expenses incurred among the three accounts set out in Section 2005 of this title separately, and assess member insurers separately for each account amounts necessary to pay the obligations of the Association under this section subsequent to a member insurer becoming an insolvent insurer, the expenses of handling covered claims subsequent to an insolvency, and other expenses authorized by the Oklahoma Property and Casualty Insurance Guaranty Association Act, Sections 2001 through 2020 of this title and Sections 2020.1 and 2020.2 of this title. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the calendar year preceding the assessment on the kinds of insurance in the account bear to the net direct written premiums of all participating insurers for the calendar year preceding the assessment on the kinds of insurance in the account. Each member insurer shall be notified in writing of the assessment not later than thirty (30) days before it is due. No member insurer may be assessed in any year an amount greater than two percent (2%) of the net direct written premiums of that member or one percent (1%) of that surplus of the member insurer as regards policyholders for the calendar year preceding the assessment on the kinds of insurance in the account, whichever is less. If the maximum assessment, together with the other assets of the Association, does not provide in any one (1) year in any account an amount sufficient to make all necessary payments from that account, the funds available may be prorated and the unpaid portion shall be paid as soon thereafter as funds become available. The Association shall pay claims in any order which it deems reasonable, including the payment of claims as the claims are received from the claimants or in groups or categories of claims. The Association may exempt or defer, in whole or in part, the assessment of any member insurer, if the assessment would cause the financial statement of the member insurer to reflect amounts of capital or surplus less than the minimum amounts required

for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance. During the period of deferment, no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payments will not reduce capital or surplus below required minimums. The payments may be refunded to those companies receiving larger assessments by virtue of the deferment, or, at the election of any company credited against future assessments. Each member insurer serving as a servicing facility may set off against any assessment authorized payments made on covered claims and expenses incurred in the payment of covered claims by a member insurer if they are chargeable to the account for which the assessment is made;

5. Investigate claims brought against the Association and adjust, compromise, settle and pay covered claims to the extent of the obligation of the Association and deny all other claims. The Association shall pay claims in any order that it may deem reasonable, including, but not limited to, the payment of claims as they are received from claimants or in groups of categories of claims. The Association shall have the right to select and to direct legal counsel under liability insurance policies for the defense of covered claims;

6. Notify claimants in this state as deemed necessary by the Commissioner and upon the request of the Commissioner, to the extent records are available to the Association. Notification may include, but shall not be limited to, a legal posting on the website of the Association;

7. a. Handle claims through employees or through one or more insurers or other persons designated as servicing facilities. Designation of a servicing facility is subject to approval of the Commissioner, but such designation may be declined by a member insurer.
- b. The Association shall have the right to review and contest as set forth in this paragraph, settlements, releases, compromises, waivers and judgments to which the insolvent insurer or its insureds were parties prior to the entry of the order of liquidation. In an action to enforce settlements, releases and judgments to which the insolvent insurer or its insureds were parties prior to the entry of the order of liquidation, the Association shall have the right to assert the following defenses:
- (1) the Association shall not be bound by a settlement, release, compromise or waiver executed by an insured or the insurer, or any judgment entered against the insured or the insurer by consent or through a failure to

exhaust all appeals, if the settlement, release, compromise waiver or judgment was:

- (a) executed or entered within one hundred twenty (120) days prior to the entry of an order of liquidation, and the insured or the insurer did not use reasonable care in entering into the settlement, release, compromise, waiver or judgment, or did not pursue all reasonable appeals of an adverse judgment, or
 - (b) executed by or taken against an insured or the insurer based on default, fraud, collusion or the failure of the insurer to defend,
- (2) if a court of competent jurisdiction finds that the Association is not bound by a settlement, release, compromise, waiver or judgment for the releases provided for in division (1) of subparagraph b of this paragraph, the settlement, release, compromise, waiver or judgment shall be set aside and the Association shall be permitted to defend any covered claim on the merits. The settlement, release, compromise, waiver or judgment shall not be considered as evidence of liability in connection with any claim brought against the Association or any other party pursuant to the Oklahoma Property and Casualty Insurance Guaranty Association Act, and
- (3) the Association shall have the right to assert any statutory defenses or rights of offset against any settlement, release, compromise or waiver executed by an insured or the insurer, or any judgment taken against the insured or the insurer.
- c. As to any covered claims arising from a judgment under any decision, verdict or finding based on the default of the insolvent insurer or its failure to defend, the Association, either on its own behalf or on behalf of an insured, may apply to have the judgment, order, decision, verdict or finding set aside by the same court or administrator that entered the judgment, claim, decision, verdict or finding and shall be permitted to defend on the merits;

8. Reimburse each servicing facility for obligations of the Association paid by the facility and for reasonable expenses incurred by the facility while handling claims on behalf of the Association and pay the other expenses of the Association authorized

by the Oklahoma Property and Casualty Insurance Guaranty Association Act;

9. Have standing to appear before any court of this state which has jurisdiction over an impaired or insolvent insurer for whom the Association is or may become obligated pursuant to the provisions of the Oklahoma Property and Casualty Insurance Guaranty Association Act. Standing shall extend to all matters germane to the powers and duties of the Association including, but not limited to, proposals for rehabilitation, acquisition, merger, reinsuring, or guaranteeing the covered policies of the impaired or insolvent insurer, and the determination of covered policies and contractual obligations of the impaired or insolvent insurer; and

10. Notwithstanding any other provision of the Oklahoma Property and Casualty Insurance Guaranty Association Act, an insurance policy issued by a member insurer and later allocated, transferred, assumed by or otherwise made the sole responsibility of another insurer pursuant to any provision of law providing for the division of an insurance company, or the statutory assumption or transfer of designated policies under which there is no remaining obligation to the transferring entity, shall be considered to have been issued by a member insurer which is an insolvent insurer for the purposes of this Act in the event that the insurer to which the policy has been allocated, transferred, assumed or otherwise made the sole responsibility of is placed in liquidation. An insurance policy that was issued by an insurer who is not a member insurer and subsequently allocated, transferred, assumed by or otherwise made the sole responsibility of a member insurer under any provision of law providing for the division of an insurance company shall not be considered to have been issued by a member insurer pursuant to this Act.

B. The Association may:

1. Employ or retain persons as are necessary to handle claims and perform other duties of the Association;

2. Borrow funds necessary to effect the purposes of the Oklahoma Property and Casualty Insurance Guaranty Association Act in accordance with the plan of operation;

3. Sue or be sued;

4. Negotiate and become a party to contracts as are necessary to carry out the purpose of the Oklahoma Property and Casualty Insurance Guaranty Association Act;

5. Refund to member insurers in proportion to the contribution of each member insurer that amount by which the assets of the Association exceed its liabilities, if at the end of any calendar year the board of directors finds that the assets of the Association exceed the liabilities as estimated by the board of directors for the coming year;

6. Lend monies to an insurer declared to be impaired by the Commissioner. The Association, with approval of the Commissioner, shall approve the amount, length and terms of the loan. "Impaired Insurer" for purposes of this section shall mean an insurer potentially unable to fulfill its contractual obligations, but shall not mean an insolvent insurer;

7. Perform other acts as are necessary or proper to effectuate the purpose of the Oklahoma Property and Casualty Insurance Guaranty Association Act;

8. Intervene as a party in interest in any supervision, conservation, liquidation, rehabilitation, impairment or receivership in which policyholders' interests and interests of the Association may be or are affected; and

9. Be designated or may contract as a servicing facility for any entity which may be recommended by the board of directors of the Association and shall be approved by the Commissioner.

Added by Laws 1980, c. 362, § 7, emerg. eff. June 27, 1980. Amended by Laws 1982, c. 258, § 3, emerg. eff. May 14, 1982; Laws 1983, c. 99, § 2, emerg. eff. May 9, 1983; Laws 1984, c. 149, § 7, eff. Nov. 1, 1984; Laws 1985, c. 328, § 16, emerg. eff. July 29, 1985; Laws 1986, c. 251, § 31, emerg. eff. June 13, 1986; Laws 1988, c. 252, § 4, eff. Nov. 1, 1988; Laws 2010, c. 159, § 6, eff. Nov. 1, 2010; Laws 2021, c. 478, § 15, emerg. eff. May 12, 2021.

§36-2008. Plan of operation and amendments.

A. The Oklahoma Property and Casualty Insurance Guaranty Association shall submit to the Commissioner a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the Association. The plan of operation and any amendments thereto shall become effective upon approval in writing by the Commissioner.

B. If the Association fails to submit a suitable plan of operation within ninety (90) days following June 27, 1980, or if at any time thereafter the Association fails to submit suitable amendments to the plan, the Commissioner shall, after notice and hearing, adopt and promulgate reasonable rules as are necessary or advisable to effectuate the provisions of Section 2001 et seq. of this title. Any rules promulgated shall continue in force until modified by the Commissioner or superseded by a plan submitted by the Association and approved by the Commissioner. All member insurers shall comply with the plan of operation.

C. The plan of operation shall:

1. Establish the procedures whereby all the powers and duties of the Association under this act will be performed;

2. Establish procedures for handling assets of the Association;

3. Require the amount and method of reimbursing members of the board of directors under Section 2006 of this title;

4. Establish procedures by which claims may be filed with the Association and establish acceptable forms of proof of covered claims;

5. Establish regular places and times for meetings of the board of directors;

6. Require that the written procedures be established for records to be kept of all financial transactions of the Association, its agents and the board of directors;

7. Provide that any member insurer aggrieved by any final action or decision of the Association may appeal to the Commissioner within thirty (30) days after the action or decision;

8. Establish the procedures whereby selections for the board of directors will be submitted to the Commissioner; and

9. Contain additional provisions necessary or proper for the execution of the powers and duties of the Association.

D. The plan of operation may provide that any or all powers and duties of the Association, except those under paragraph 3 of subsection A and paragraph 2 of subsection B of Section 2007 of this title, are delegated to a corporation, association or other organization which performs or will perform functions similar to those of this Association, or its equivalent. The corporation, association or organization shall be reimbursed as a servicing facility would be reimbursed and shall be paid for its performance of any other functions of the Association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the Commissioner, and may be made only to a corporation, association or organization which extends protection not substantially less favorable and effective than that provided by Section 2001 et seq. of this title.

Added by Laws 1980, c. 362, § 8, emerg. eff. June 27, 1980. Amended by Laws 1986, c. 251, § 32, emerg. eff. June 13, 1986; Laws 2010, c. 159, § 7, eff. Nov. 1, 2010; Laws 2021, c. 478, § 16, emerg. eff. May 12, 2021.

§36-2009. Powers and duties of Commissioner.

A. The Commissioner shall:

1. Notify the Oklahoma Property and Casualty Insurance Guaranty Association of the existence of an insolvent insurer not later than three (3) days after notice of the determination is received. The Association shall be entitled to a copy of a complaint seeking an order of liquidation with a finding of insolvency against a member company at the same time that the complaint is filed with a court of competent jurisdiction; and

2. Provide the Association with a statement of the net direct written premiums of each member insurer upon the request of the board of directors.

B. The Commissioner may:

1. Suspend or revoke, after the notice and hearing, the certificate of authority to transact insurance in this state of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the Commissioner may levy a fine on any member insurer which fails to pay an assessment when due. The fine shall not exceed five percent (5%) of the unpaid assessment per month, except that no fine shall be less than One Hundred Dollars (\$100.00) per month;

2. Revoke the designation of any servicing facility if the Commissioner finds claims are being handled unsatisfactorily; or

3. Examine or audit the Association.

C. Any final action or order of the Commissioner under the Oklahoma Property and Casualty Insurance Guaranty Association Act shall be subject to judicial review in a court of competent jurisdiction.

Added by Laws 1980, c. 362, § 9, emerg. eff. June 27, 1980. Amended by Laws 2010, c. 159, § 8, eff. Nov. 1, 2010.

§36-2010. Payment of covered claims - Recovery from certain persons - Priority of claims.

A. Any person recovering under the Oklahoma Property and Casualty Insurance Guaranty Association Act shall be deemed to have assigned the rights of the person under the policy to the Oklahoma Property and Casualty Insurance Guaranty Association to the extent of the recovery of the person from the Association. Every insurer or claimant seeking the protection of this act shall cooperate with the Association to the same extent as the person would have been required to cooperate with the insolvent insurer. In the case of an insolvent insurer operating on a plan with assessment liability, payment of covered claims by the Association shall not operate to reduce the liability of insureds to the receiver, liquidator or statutory successor for unpaid assessments.

B. The Association shall have the right to recover from any person who is an affiliate of the insolvent insurer all amounts paid by the Association on behalf of that person pursuant to the provisions of the Oklahoma Property and Casualty Insurance Guaranty Association Act, whether for indemnity, defense or otherwise.

C. The receiver, liquidator or statutory successor of an insolvent insurer shall be bound by settlements of covered claims by the Association or a similar organization in another state. The Association shall have a priority over general creditors of the insolvent insurer against the assets of the insolvent insurer equal to the amount of covered claims paid by the Association pursuant to the Oklahoma Property and Casualty Insurance Guaranty Association Act. No other priority under the provisions of this section unless the laws of such other state grant a similar priority to the Association, in which case such other association or similar

organization of another state shall have a priority against the assets of the insolvent insurer equal to that given to the Association by such other state.

D. The Association shall periodically file with the receiver or liquidator of the insolvent insurer statements of the covered claims paid by the Association and estimates of anticipated claims on the Association which shall preserve the rights of the Association against the assets of the insolvent insurer.

Added by Laws 1980, c. 362, § 10, emerg. eff. June 27, 1980.

Amended by Laws 1986, c. 251, § 33, eff. Nov. 1, 1986; Laws 2010, c. 159, § 9, eff. Nov. 1, 2010.

§36-2011. Proposal to distribute assets of insolvent company - Notice.

A. Within one hundred twenty (120) days of a final determination of insolvency of a company by a court of competent jurisdiction of this state, the receiver shall make application to the court for approval of a proposal to disburse assets out of such company's marshalled assets from time to time as such assets become available to the Oklahoma Property and Casualty Insurance Guaranty Fund and to any entity or person performing a similar function in another state. The Oklahoma Property and Casualty Insurance Guaranty Fund and any entity or person performing a similar function in other states shall hereinafter be referred to collectively as the Associations.

B. Such proposal shall at least include provisions for:

1. Reserving amounts for the payment of expenses of administration and claims falling within priorities higher than that of the Fund;

2. Disbursement of the assets marshalled to date and subsequent disbursements of assets as they become available;

3. Equitable allocation of disbursements to each of the associations entitled thereto;

4. The securing by the receiver from each of the associations entitled to disbursements of an agreement to return to the receiver such assets previously disbursed as may be required to pay claims of secured creditors and claims falling within priorities higher than that of the Fund in accordance with such priorities. No bond shall be required of any such association; and

5. A full report to be made by the association to the receiver accounting for all assets so disbursed to the association on such assets and any other matter as the court may direct.

C. The receiver's proposal shall provide for disbursements to the association in amounts estimated at least equal to the claim payments made or to be made thereby for which such associations could assert a claim against the receiver, and shall further provide that if the assets available for disbursement from time to time do

not equal or exceed the amount of such claim payments made or to be made by the association then disbursements shall be in the amount of available assets.

D. Notice of such application shall be given to the associations in and to the Commissioners of Insurance of each of the states. Any such notice shall be deemed to have been given when deposited in the United States certified mail, first class postage prepaid, at least thirty (30) days prior to submission of such application to the court. Action on the application may be taken by the court provided the above required notice has been given, and provided further that the receiver's proposal complies with paragraphs 1 and 4 of subsection B of this section. Laws 1980, c. 362, § 11, emerg. eff. June 27, 1980.

§36-2012. Exhaustion of rights under other policies, governmental program or associations.

A. 1. Any person having a claim against an insurer shall be required to first exhaust all coverage provided by another policy if it arises from the same facts, injury or loss that gave rise to the covered claim against the Oklahoma Property and Casualty Insurance Guaranty Association. The requirement to exhaust all coverage shall apply without regard to whether the other insurance policy is a policy written by a member insurer. However, no person shall be required to exhaust any right under the policy of an insolvent insurer or any right under a life insurance policy.

2. Any amount payable on a covered claim under the Oklahoma Property and Casualty Insurance Guaranty Association Act shall be reduced by the full applicable limits stated in the insurance policy or by the amount of the recovery under the insurance policy as provided herein. The Association shall receive a full credit for the stated limits, unless the claimant demonstrates that the claimant used reasonable efforts to exhaust all coverage and limits applicable under the other insurance policy. If the claimant demonstrates that the claimant used reasonable efforts to exhaust all coverage and limits applicable under the insurance policy, or if there are no applicable stated limits under the policy, the Association shall receive a full credit for the total recovery.

B. Any person having a claim which may be recovered under more than one insurance guaranty association or its equivalent in another state shall seek recovery first from the association of the place of residence of the insured. If it is a first party claim for damage to property with a permanent location, the person shall seek recovery first from the association of the state where the property is located, and if it is a workers' compensation claim, the person shall seek recovery first from the association of the residence of the claimant. Any recovery under this act shall be reduced by the

amount of recovery from any other insurance guaranty association or its equivalent.

Added by Laws 1980, c. 362, § 12, emerg. eff. June 27, 1980.

Amended by Laws 1986, c. 251, § 34, eff. Nov. 1, 1986; Laws 2010, c. 159, § 10, eff. Nov. 1, 2010.

§36-2013. Repealed by Laws 2010, c. 159, § 16, eff. Nov. 1, 2010.

§36-2014. Scope of covered claims.

A covered claim shall not include any claim filed with the Association after the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer.

Added by Laws 1980, c. 362, § 14, emerg. eff. June 27, 1980.

§36-2015. Prohibited acts.

No person, including an insurer, agent or affiliate of an insurer shall make, publish, disseminate, circulate or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in any newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio station or television station, or in any other way, any advertisement, announcement or statement which uses the existence of the Oklahoma Property and Casualty Insurance Guaranty Association for the purpose of sales, solicitation or inducement to purchase any form of insurance covered by the Oklahoma Property and Casualty Insurance Guaranty Association Act. This section shall not apply to the Oklahoma Property and Casualty Insurance Guaranty Association or to any other entity which does not sell or solicit insurance.

Laws 1980, c. 362, § 15, emerg. eff. June 27, 1980.

§36-2016. Examination of Association - Report.

The Oklahoma Property and Casualty Insurance Guaranty Association shall be subject to the examination by the Commissioner and a report shall be made not less than annually by the board of directors concerning the financial condition of the Association. The report shall be made in such form as the Commissioner shall prescribe.

Added by Laws 1980, c. 362, § 16, emerg. eff. June 27, 1980.

Amended by Laws 2010, c. 159, § 11, eff. Nov. 1, 2010.

§36-2017. Exemption from taxes and fees.

The Association shall be exempt from payment of all fees and all taxes levied by this state or any of its subdivisions.

Laws 1980, c. 362, § 17, emerg. eff. June 27, 1980.

§36-2018. Payment of assessment - Effect on rate increase or decrease.

Any member insurer who has paid an assessment pursuant to the Oklahoma Property and Casualty Insurance Guaranty Association Act shall include amounts sufficient to recoup a sum equal to the amounts paid to the Oklahoma Property and Casualty Insurance Guaranty Association by the member insurer, less any amounts returned to the member insurer by the Association. Rates shall not be deemed excessive because they contain an additional amount reasonably calculated to recoup all assessments paid by the member insurer in its next filing for a rate increase or decrease before the Insurance Commissioner.

Added by Laws 1980, c. 362, § 19, emerg. eff. June 27, 1980.

Amended by Laws 1982, c. 258, § 4, emerg. eff. May 14, 1982; Laws 2006, c. 264, § 51, eff. July 1, 2006; Laws 2010, c. 159, § 12, eff. Nov. 1, 2010.

§36-2019. Liability of certain persons.

There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer or its agent or employees, the Association, its directors, employees or agents, for any action taken by them in the performance of their powers and duties under this act.

Laws 1980, c. 362, § 19, emerg. eff. June 27, 1980.

§36-2020. Stay of proceedings - Access to records.

All proceedings in which the insolvent insurer, its policyholder, or the Oklahoma Property and Casualty Insurance Guaranty Association is a party in any court in this state shall be stayed six (6) months and additional time may be determined by the court from the date when insolvency is determined or an ancillary proceeding is instituted in the state, whichever is later, to permit proper defense by the association of all pending causes of action. The liquidator, receiver or statutory successor of an insolvent insurer covered by this act shall permit the board or its authorized representative access to the records of the insolvent insurer as are necessary to the board in carrying out its functions under this act with regard to the covered claims. In addition, the liquidator, receiver or statutory successor shall provide the board or its representative with copies of those records upon the request of the board and at the expense of the board.

Added by Laws 1985, c. 328, § 18, emerg. eff. July 29, 1985.

Amended by Laws 1986, c. 251, § 35, eff. Nov. 1, 1986; Laws 2010, c. 159, § 13, eff. Nov. 1, 2010.

§36-2020.1. Efficient coordination and cooperation with receivers - Uniform Data Standards.

The Oklahoma Property and Casualty Insurance Guaranty Association, in cooperation with other obligated or potentially obligated guaranty associations, or their designated representatives, shall make all reasonable efforts to coordinate and cooperate with receivers, or their designated representatives, in the most efficient and uniform manner, including the use of Uniform Data Standards as promulgated or approved by the National Association of Insurance Commissioners.
Added by Laws 2010, c. 159, § 14, eff. Nov. 1, 2010.

§36-2020.2. High net worth insured claims - Obligation to pay - Procedures.

A. For purposes of this section, "high net worth insured" means any insured whose net worth exceeds Fifty Million Dollars (\$50,000,000.00) on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer; provided that the net worth of an insured on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis.

B. 1. The Oklahoma Property and Casualty Insurance Guaranty Association shall not be obligated to pay any first party claims by a high net worth insured; and

2. The Association shall have the right to recover from a high net worth insured all amounts paid by the association to or on behalf of the insured, whether for indemnity, defense or otherwise.

C. The Association shall not be obligated to pay any claim that would otherwise be a covered claim that is an obligation to or on behalf of a person who has a net worth greater than that allowed by the insurance guaranty association law of the state of residence of the claimant at the time specified by the applicable law of that state, and which association has denied coverage to that claimant on that basis.

D. The Association shall establish reasonable procedures for requesting financial information from insureds on a confidential basis for purposes of applying this section, provided that the financial information may be shared with any other association similar to the association and the liquidator for the insolvent insurer on the same confidential basis. Any request to an insured seeking financial information shall advise the insured of the consequences of failing to provide the financial information. If an insured refuses to provide the requested financial information where it is requested and available, the Association may, until the time as the information is provided, provisionally deem the insured to be a high net worth insured for the purpose of denying a claim under subsection B of this section.

E. In any lawsuit contesting the applicability of this section where the insured has refused to provide financial information under

the procedure established pursuant to subsection D of this section, the insured shall bear the burden of proof concerning its net worth at the relevant time. If the insured fails to prove that its net worth at the relevant time was less than the applicable amount, the court shall award the association its full costs, expenses and reasonable attorney fees in contesting the claim.

Added by Laws 2010, c. 159, § 15, eff. Nov. 1, 2010.

§36-2021. Short title.

This act shall be known and may be cited as the Oklahoma Life and Health Insurance Guaranty Association Act.

Laws 1981, c. 133, § 1.

§36-2022. Purpose of act.

A. The purpose of the Oklahoma Life and Health Insurance Guaranty Association Act is to protect, subject to certain limitations, the persons specified in subsection A of Section 2025 of this title, against failure in the performance of contractual obligations, under life, health, and annuity policies, plans or contracts specified in subsection B of Section 2025 of this title, because of the impairment or insolvency of the member insurer that issued the policies, plans or contracts.

B. To provide this protection, an association of member insurers has been created and exists to pay benefits and to continue coverages as limited in this act, and members of the Association are subject to assessment to provide funds to carry out the purposes of this act.

Added by Laws 1981, c. 133, § 2. Amended by Laws 1987, c. 177, § 1, eff. Nov. 1, 1987; Laws 2019, c. 384, § 1, eff. Nov. 1, 2019.

§36-2023. Creation - Membership - Administration - Supervision.

A. There is created a nonprofit legal entity to be known as the Oklahoma Life and Health Insurance Guaranty Association. All member insurers shall be and remain members of the Association as a condition of their authority to transact insurance or health maintenance organization business in this state.

B. The Association shall perform its functions under a plan of operation established and approved in accordance with this act and shall exercise its powers through the Board of Directors established in this act. For purposes of administration and assessment, the Association shall maintain three accounts:

1. The health account;
2. The life insurance account; and
3. The annuity account.

C. The Association shall come under the immediate supervision of the Insurance Commissioner and shall be subject to the applicable provisions of the insurance laws of this state.

Added by Laws 1981, c. 133, § 3. Amended by Laws 2019, c. 384, § 2, eff. Nov. 1, 2019; Laws 2021, c. 478, § 17, emerg. eff. May 12, 2021.

§36-2024. Definitions.

As used in the Oklahoma Life and Health Insurance Guaranty Association Act:

1. "Account" means one of the three accounts created under Section 2023 of this title;

2. "Association" means the Oklahoma Life and Health Insurance Guaranty Association created in Section 2023 of this title;

3. "Commissioner" means the Oklahoma Insurance Commissioner;

4. "Contractual obligation" means an obligation under a policy or contract or certificate under a group policy or contract, or portion thereof for which coverage is provided under Section 2025 of this title;

5. "Covered contract" or "covered policy" means a policy or contract or portion of a policy or contract for which coverage is provided under Section 2025 of this title;

6. "Extra-contractual claims" includes, but is not limited to, claims relating to bad faith in the payment of claims, punitive or exemplary damages or attorneys fees and costs;

7. "Health benefit plan" means any hospital or medical expense policy or certificate or health maintenance organization subscriber contract or any other similar health contract. Health benefit plan does not include:

- a. accident-only insurance,
- b. credit insurance,
- c. dental-only insurance,
- d. vision-only insurance,
- e. Medicare supplemental insurance,
- f. benefits for long-term care, home health care, community-based care, or any combination thereof,
- g. disability income insurance,
- h. coverage for on-site medical clinics, or
- i. specified disease, hospital confinement indemnity or limited health insurance if the types of coverage do not provide coordination of benefits and are provided under separate policies or certificates;

8. "Impaired insurer" means a member insurer which, after the effective date of this act, is not an insolvent insurer and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction;

9. "Insolvent insurer" means a member insurer which, after the effective date of this act, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency;

10. "Member insurer" means any nonprofit hospital service and medical indemnity corporation and any insurer or health maintenance organization licensed or that holds a certificate of authority to transact in this state any kind of insurance or health maintenance organization business for which coverage is provided under Section 2025 of this title, and includes any insurer or health maintenance organization whose license or certificate of authority in this state may have been suspended, revoked, not renewed or voluntarily withdrawn, but does not include:

- a. a fraternal benefit society,
- b. a mandatory state-pooling plan,
- c. a mutual assessment company or other person that operates on an assessment basis,
- d. an insurance exchange,
- e. an organization that has a certificate or license limited to the issuance of charitable gift annuities under Sections 4071 through 4082 of this title, or
- f. any entity similar to any of the above;

11. "Moody's Corporate Bond Yield Average" means the Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto;

12. "Owner", "policyholder", "policy owner" or "contract owner" means the person who is identified as the legal owner of a policy or contract under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the member insurer. Owner, policyholder, policy owner or contract owner does not include persons with a mere beneficial interest in a policy or contract;

13. "Person" means an individual, corporation, limited liability company, partnership, association, governmental body or entity, or voluntary organization;

14. "Premiums" means amounts or considerations by whatever name called, received on covered policies or contracts less returned premiums, considerations and deposits and less dividends and experience credits. "Premiums" does not include amounts or considerations received for policies or contracts or for the portions of any policies or contracts for which coverage is not provided under subsection B of Section 2025 of this title except that assessable premium shall not be reduced on account of subparagraph c of paragraph 2 of subsection B of Section 2025 of this title relating to interest limitations and paragraph 2 of subsection C of Section 2025 of this title relating to limitations with respect to one individual, one participant and one policy or contract owner. Premiums does not include:

- a. premiums on an unallocated annuity contract, or

- b. premiums in excess of Five Million Dollars (\$5,000,000.00) on multiple non-group policies of life insurance owned by one owner, whether the policy or contract owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, regardless of the number of policies or contracts held by the owner;

15. "Principal place of business" of a person other than a natural person means the single state in which the natural persons who establish policy for the direction, control and coordination of the operations of the entity as a whole primarily exercise that function, determined by the Association in its reasonable judgment by considering the following factors:

- a. the state in which the primary executive and administrative headquarters of the entity are located,
- b. the state in which the principal office of the chief executive officer of the entity is located,
- c. the state in which the board of directors or similar governing person or persons of the entity conducts the majority of its meetings,
- d. the state in which the executive or management committee of the board of directors or similar governing person or persons of the entity conducts the majority of its meetings,
- e. the state from which the management of the overall operations of the entity is directed, and
- f. in the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the factors listed in subparagraphs a through e of this paragraph;

16. "Receivership court" means the court in the insolvent or impaired state of the insurer having jurisdiction over the conservation, rehabilitation or liquidation of the member insurer;

17. "Resident" means a person to whom a contractual obligation is owed and who resides in this state on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer. A person may be a resident of only one state, which in the case of a person other than a natural person shall be its principal place of business. Citizens of the United States that are either residents of foreign countries or residents of the United States possessions, territories or protectorates that do not have an association similar to the Association created by the Oklahoma Life and Health Insurance Guaranty Association Act, shall be deemed

residents of the state of domicile of the insurer that issued the policy or contract;

18. "State" means a state of the United States, the District of Columbia, Puerto Rico, or a United States possession, territory or protectorate;

19. "Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by a plaintiff or other claimant;

20. "Supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, health or annuity policy or contract; and

21. "Unallocated annuity contract" means an annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate. Added by Laws 1981, c. 133, § 4. Amended by Laws 1987, c. 177, § 2, eff. Nov. 1, 1987; Laws 1988, c. 291, § 4, eff. Nov. 1, 1988; Laws 1994, c. 294, § 3, eff. Sept. 1, 1994; Laws 2010, c. 145, § 1, eff. Nov. 1, 2010; Laws 2019, c. 384, § 3, eff. Nov. 1, 2019.

§36-2025. Oklahoma Life and Health Insurance Guaranty Association Act - Coverage - Liability.

A. For the policies and contracts specified in subsection B of this section, the Oklahoma Life and Health Insurance Guaranty Association Act shall provide coverage:

1. a. To persons, who regardless of where they reside, except for nonresident certificate holders under group policies or contracts, are the beneficiaries, assignees or payees, including health care providers rendering services covered under health insurance policies or certificates, of the persons covered under subparagraph b of this paragraph,
- b. To persons who are owners of or certificate holders or enrollees under the policies or contracts, other than structured settlement annuities, and in each case who:
 - (1) are residents, or
 - (2) are not residents, but only under all of the following conditions:
 - (a) the member insurer that issued the policies or contracts are domiciled in this state,
 - (b) the states in which the persons reside have associations similar to the Oklahoma Life and Health Insurance Guaranty Association created by this act, and the persons are not eligible for coverage by an association in any other state due to the fact that the

insurer or health maintenance organization was not licensed in the state at the time specified in the guaranty association law of the state;

2. Subparagraphs a and b of paragraph 1 of this subsection shall not apply to structured settlement annuities specified in subsection B of this section and in the Oklahoma Life and Health Insurance Guaranty Association Act shall, except as provided in paragraphs 3 and 4 of this subsection, provide coverage to a person who is a payee under a structured settlement annuity or a beneficiary of a payee if the payee is deceased, if the payee:

a. is a resident, regardless of where the contract owner resides, or

b. is not a resident, but only under both of the following conditions:

(1) (a) the contract owner of the structured settlement annuity is a resident, or

(b) the contract owner of the structured settlement annuity is not a resident but:

i. the insurer that issued the structured settlement annuity is domiciled in this state, and

ii. the state in which the contract owner resides has an association similar to the association created by the Oklahoma Life and Health Insurance Guaranty Association Act, and

(2) neither the payee nor beneficiary nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides;

3. The Oklahoma Life and Health Insurance Guaranty Association Act shall not provide coverage to a person who is a payee or beneficiary of a contract owner resident of this state, if the payee or beneficiary is afforded coverage by the association of another state; and

4. The Oklahoma Life and Health Insurance Guaranty Association Act is intended to provide coverage to a person who is a resident of this state and in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under the Oklahoma Life and Health Insurance Guaranty Association Act is provided coverage under the laws of any other state, the person shall not be provided coverage under the Oklahoma Life and Health Insurance Guaranty Association Act. In determining the application of the provisions of this paragraph to situations where a person could be covered by the association of more than one state, whether as an owner, payee, enrollee, beneficiary or

assignee, the Oklahoma Life and Health Insurance Association Act shall be construed in conjunction with the laws of other states to result in coverage by only one association.

B. 1. The Oklahoma Life and Health Insurance Guaranty Association Act shall provide coverage to the persons specified in subsection A of this section for policies or contracts of direct, non-group life insurance, health insurance, which for the purposes of this act includes health maintenance organization subscriber contracts and certificates, or annuities and supplemental policies or contracts to any of these, and for certificates under direct group policies and contracts, except as limited by the Oklahoma Life and Health Insurance Guaranty Association Act. Annuity contracts and certificates under group annuity contracts include allocated funding agreements, structured settlement annuities and any immediate or deferred annuity contracts.

2. Except as provided in paragraph 3 of this subsection, the Oklahoma Life and Health Insurance Guaranty Association Act shall not provide coverage for:

- a. a portion of a policy or contract not guaranteed by the insurer, or under which the risk is borne by the policy or contract owner,
- b. a policy or contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract,
- c. a portion of a policy or contract to the extent that the rate of interest on which it is based, or the interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value:
 - (1) averaged over the period of four (4) years prior to the date on which the Association becomes obligated with respect to the policy or contract, exceeds a rate of interest determined by subtracting two (2) percentage points from Moody's Corporate Bond Yield Average averaged for that same four-year period or for such lesser period if the policy or contract was issued less than four (4) years before the Association became obligated, and
 - (2) on and after the date on which the Association becomes obligated with respect to the policy or contract, exceeds the rate of interest determined by subtracting three (3) percentage points from Moody's Corporate Bond Yield Average as most recently available,

- d. a portion of a policy or contract issued to a plan or program of an employer, association or other person to provide life, health or annuity benefits to its employees, members or others, to the extent that the plan or program is self-funded or uninsured, including but not limited to benefits payable by an employer, association or other person under:
 - (1) a Multiple Employer Welfare Arrangement as defined in 29 U.S.C. Section 1144,
 - (2) a minimum premium group insurance plan,
 - (3) a stop-loss group insurance plan, or
 - (4) an administrative services only contract,
- e. a portion of a policy or contract to the extent that it provides for:
 - (1) dividends or experience rating credits,
 - (2) voting rights, or
 - (3) payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract,
- f. a policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue the policy or contract in this state,
- g. a portion of a policy or contract to the extent that the assessments required by Section 2030 of this title with respect to the policy or contract are preempted by federal or state law,
- h. an obligation that does not arise under the express written terms of the policy or contract issued by the member insurer to the enrollee, certificate holder or contract or policy owner, including without limitation:
 - (1) claims based on marketing materials,
 - (2) claims based on side letters, riders or other documents that were issued by the member insurer without meeting applicable policy or contract form filing or approval requirements,
 - (3) misrepresentations of or regarding policy or contract benefits,
 - (4) extra-contractual claims, or
 - (5) a claim for penalties or consequential or incidental damages,
- i. a contractual agreement that establishes the obligations of the member insurer to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio

of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer,

- j. an unallocated annuity contract,
- k. a portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under the Oklahoma Life and Health Insurance Guaranty Association Act, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this subparagraph, the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and will not be subject to forfeiture, or
- 1. a policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Part C or Part D of Subchapter XVIII, Chapter 7 of Title 42 of the United States Code, commonly known as Medicare Part C or Part D, or Subchapter XIX, Chapter 7 of Title 42 of the United States Code or any regulations issued pursuant thereto.

3. The exclusion from coverage in this section shall not apply to any portion of a policy or contract, including a rider that provides long-term care or any other health insurance benefits.

C. The benefits that the Association may become obligated to cover shall in no event exceed the lesser of:

1. The contractual obligations for which the member insurer is liable or would have been liable if it were not an impaired or insolvent insurer; or

2. a. with respect to any one life, regardless of the number of policies or contracts:

(1) Three Hundred Thousand Dollars (\$300,000.00) in life insurance death benefits, but not more than One Hundred Thousand Dollars (\$100,000.00) in net

- cash surrender and net cash withdrawal values for life insurance,
- (2) for health insurance benefits:
 - (a) One Hundred Thousand Dollars (\$100,000.00) for coverages not defined as disability income insurance or health benefit plans or long-term care insurance as defined in Section 4424 of this title, including any net cash surrender and net cash withdrawal values,
 - (b) Three Hundred Thousand Dollars (\$300,000.00) for insurance providing income payments to an insured wage earner when income is interrupted or terminated because of illness, sickness or accident, commonly known as disability income insurance and Three Hundred Thousand Dollars (\$300,000.00) for long-term care insurance as defined in Section 4424 of this title, and
 - (c) Five Hundred Thousand Dollars (\$500,000.00) for health benefit plans, or
 - (3) Three Hundred Thousand Dollars (\$300,000.00) in the present value of annuity benefits, including net cash surrender and net cash withdrawal values, or
- b. with respect to each payee of a structured settlement annuity or beneficiary or beneficiaries of the payee if the payee is deceased, Three Hundred Thousand Dollars (\$300,000.00) in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values,
- c. however, in no event shall the Association be obligated to cover more than:
- (1) an aggregate of Three Hundred Thousand Dollars (\$300,000.00) in benefits with respect to any one life under this subparagraph and subparagraphs a and b of this paragraph except with respect to health benefit plans under division (2) of subparagraph a of this paragraph, in which case the aggregate liability of the Association shall not exceed Five Hundred Thousand Dollars (\$500,000.00) with respect to any one individual, or
 - (2) with respect to one owner of multiple non-group policies of life insurance, whether the policy or contract owner is an individual, firm, corporation or other person, and whether the

persons insured are officers, managers, employees or other persons, more than Five Million Dollars (\$5,000,000.00) in benefits, regardless of the number of policies and contracts held by the owner,

- d. the limitations set forth in this subsection are limitations on benefits for which the Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the obligations of the Association under the Oklahoma Life and Health Insurance Guaranty Association Act may be met by the use of assets attributable to covered policies or reimbursed to the Association pursuant to its subrogation and assignment rights,
- e. for purposes of the Oklahoma Life and Health Insurance Guaranty Association Act, benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

D. In performing its obligations to provide coverage under Section 2028 of this title, the Association shall not be required to guarantee, assume, reinsure, reissue or perform, or cause to be guaranteed, assumed, reinsured, reissued or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

Added by Laws 1981, c. 133, § 5. Amended by Laws 1987, c. 177, § 3, eff. Nov. 1, 1987; Laws 2010, c. 145, § 2, eff. Nov. 1, 2010; Laws 2019, c. 384, § 4, eff. Nov. 1, 2019.

§36-2026. Board of directors - Membership - Term - Vacancies - Approval - Compensation.

A. The Board of Directors of the Oklahoma Life and Health Insurance Guaranty Association shall consist of not less than seven (7) nor more than eleven (11) member insurers serving terms as established in the procedural rules of the Association. A majority of the Board shall be selected from the fifty (50) member insurers which write the largest volume of life and accident and health premiums and annuity considerations for the previous year. The members of the Board shall be selected by member insurers subject to the approval of the Insurance Commissioner. Vacancies on the Board shall be filled for the remaining period of the term by a majority

vote of the remaining Board members, subject to the approval of the Commissioner.

B. In calculating total premium for Board qualification purposes, premiums collected by different members of the same multi-insurer group may be attributable to each member of the group; provided, no two members of the same group shall serve on the Board at the same time.

C. In approving selections, the Commissioner shall consider, among other things, whether all member insurers are fairly represented.

D. Members of the Board may be reimbursed by the Association for expenses incurred by them as members of the Board, but members of the Board shall not otherwise be compensated by the Association for their services.

Added by Laws 1981, c. 133, § 6. Amended by Laws 1998, c. 237, § 1, eff. July 1, 1998; Laws 2019, c. 384, § 5, eff. Nov. 1, 2019.

§36-2027. Procedural rules and amendments.

A. 1. The Oklahoma Life and Health Insurance Guaranty Association shall submit to the Insurance Commissioner procedural rules and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the Association. The procedural rules and any amendments thereto shall become effective upon approval in writing by the Commissioner.

2. If the Association fails to submit suitable procedural rules within one hundred eighty (180) days following the effective date of this act or if at any time thereafter the Association fails to submit suitable amendments to the rules, the Commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary to effectuate the provisions of the Oklahoma Life and Health Insurance Guaranty Association Act. Such rules shall continue in force until modified by the Commissioner or superseded by rules submitted by the Association and approved by the Commissioner. All member insurers shall comply with the procedural rules.

B. The procedural rules shall, in addition to requirements enumerated elsewhere in the Oklahoma Life and Health Insurance Guaranty Association Act:

1. Establish procedures for handling the assets of the Association;

2. Establish regular places and times for meeting of the Board of Directors;

3. Establish procedures for records to be kept of all financial transactions of the Association, its agents, and the Board of Directors;

4. Establish the procedures whereby selections for the Board of Directors will be made and submitted to the Commissioner;

5. Establish any additional procedures for assessments under Section 2030 of this title; and

6. Contain additional provisions necessary or proper for the execution of the powers and duties of the Association.

C. The procedural rules may provide that any or all powers and duties of the Association, except those under Section 2030 of this title, are delegated to a corporation, association or other organization which performs or will perform functions similar to those of this Association, or its equivalent, in two or more states if there is a reciprocal agreement with such states to provide similar services. Such a corporation, association or organization shall be reimbursed for any payments made on behalf of the Association and shall be paid for the performance of any function of the Association. A delegation of powers or duties under this subsection shall take effect only with the approval of both the Board and the Commissioner, and may be made only to a corporation, association or organization which extends protection not substantially less favorable and effective than that provided by this act.

Added by Laws 1981, c. 133, § 7. Amended by Laws 2019, c. 384, § 6, eff. Nov. 1, 2019.

§36-2028. Impaired or insolvent insurers.

A. If a member insurer is an impaired insurer, the Oklahoma Life and Health Insurance Guaranty Association may, in its discretion, and subject to any conditions imposed by the Association that do not impair the contractual obligations of the impaired insurer and that are approved by the Insurance Commissioner:

1. Guarantee, assume, reissue or reinsure, or cause to be guaranteed, assumed, reissued or reinsured, any or all of the policies or contracts of the impaired insurer; or

2. Provide monies, pledges, notes, guarantees or other means as are proper to effectuate paragraph 1 of this subsection, and assure payment of the contractual obligations of the impaired insurer pending action under paragraph 1 of this subsection.

B. If a member insurer is an insolvent insurer, the Association shall, in its discretion, either:

1. a. (1) guarantee, assume, reissue or reinsure, or cause to be guaranteed, assumed, reissued or reinsured, the policies or contracts of the insolvent insurer, or

(2) assure payment of the contractual obligations of the insolvent insurer, and

b. provide monies, pledges, loans, notes, guarantees or other means as are reasonably necessary to discharge the duties of the Association; or

2. Provide benefits and coverages in accordance with the following provisions:

- a. with respect to policies and contracts, assure payment of benefits that would have been payable under the policies or contracts of the insolvent insurer for claims incurred:
 - (1) with respect to group policies and contracts, not later than the earlier of the next renewal date under those policies or contracts or forty-five (45) days, but in no event less than thirty (30) days, after the date on which the Association becomes obligated with respect to the policies and contracts, or
 - (2) with respect to non-group policies, contracts, and annuities not later than the earlier of the next renewal date, if any, under the policies or contracts for one (1) year, but in no event less than thirty (30) days, from the date on which the Association becomes obligated with respect to the policies or contracts,
- b. make diligent efforts to provide all known insureds, enrollees or annuitants for non-group policies and contracts, or group policy or contract owners with respect to group policies and contracts, thirty (30) days' notice of the termination of the benefits provided pursuant to subparagraph a of this paragraph,
- c. with respect to non-group policies and contracts covered by the Association, make available to each known insured, enrollee or annuitant, or owner if other than the insured, enrollee or annuitant, and with respect to an individual formerly an insured, enrollee or annuitant under a group policy or contract who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of subparagraph d of this paragraph, if the insureds, enrollees or annuitants had a right under law or the terminated policy, contract or annuity to convert coverage to individual coverage or to continue an individual policy, contract or annuity in force until a specified age or for a specified time, during which the insurer or health maintenance organization had no right unilaterally to make changes in any provision of the policy, contract or annuity or had a right only to make changes in premium by class,
- d. (1) in providing the substitute coverage required under subparagraph c of this paragraph, the

- Association may offer either to reissue the terminated coverage or to issue an alternative policy or contract at actuarially justified rates, subject to the prior approval of the Insurance Commissioner,
- (2) alternative or reissued policies or contracts shall be offered without requiring evidence of insurability, and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy or contract, and
 - (3) the Association may reinsure any alternative or reissued policy or contract,
- e. (1) alternative policies or contracts adopted by the Association shall be subject to the approval of the Insurance Commissioner. The Association may adopt alternative policies or contracts of various types for future issuance without regard to any particular impairment or insolvency,
- (2) alternative policies or contracts shall contain at least the minimum statutory provisions required in this state and provide benefits that shall not be unreasonable in relation to the premium charged. The Association shall set the premium in accordance with a table of rates that it shall adopt. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but shall not reflect any changes in the health of the insured after the original policy or contract was last underwritten,
 - (3) any alternative policy or contract issued by the Association shall provide coverage of a type similar to that of the policy or contract issued by the impaired or insolvent insurer, as determined by the Association,
- f. if the Association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy or contract, the premium shall be actuarially justified and set by the Association in accordance with the amount of insurance or coverage provided and the age and class of risk, subject to prior approval of the Insurance Commissioner,
- g. the obligations of the Association with respect to coverage under any policy or contract of the impaired or insolvent insurer or under any reissued or

alternative policy or contract shall cease on the date the coverage or policy or contract is replaced by another similar policy or contract by the policy or contract owner, the insured, enrollee or the Association,

- h. when proceeding under paragraph 2 of subsection B of this section with respect to a policy or contract carrying guaranteed minimum interest rates, the Association shall assure the payment or crediting of a rate of interest consistent with subparagraph c of paragraph 2 of subsection B of Section 2025 of this title.

C. Nonpayment of premiums within thirty-one (31) days after the date required under the terms of any guaranteed, assumed, alternative or reissued policy or contract or substitute coverage shall terminate the Association's obligations under the policy, contract or coverage under the Oklahoma Life and Health Insurance Guaranty Association Act with respect to the policy, contract or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of the Oklahoma Life and Health Insurance Guaranty Association Act.

D. Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the Association. If the liquidator of an insolvent insurer requests, the Association shall provide a report to the liquidator regarding the premium collected by the Association. The Association shall be liable for unearned premiums due to policy or contract owners arising after the entry of the order.

E. The protection provided by the Oklahoma Life and Health Insurance Guaranty Association Act shall not apply where any guaranty protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state.

F. In carrying out its duties under subsection B of this section the Association may, subject to approval by a court in this state:

- 1. Impose permanent policy or contract liens in connection with a guarantee, assumption or reinsurance agreement, if the Association finds that the amounts which can be assessed under this act are less than the amounts needed to assure full and prompt performance of the duties of the Association under the Oklahoma Life and Health Insurance Guaranty Association Act, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of permanent policy or contract liens, to be in the public interest; and

2. Impose temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value. In addition, in the event of a temporary moratorium or moratorium charge imposed by the receivership court on payment of cash values or policy loans, or on any other right to withdraw funds held in conjunction with policies or contracts, out of the assets of the impaired or insolvent insurer, the Association may defer the payment of cash values, policy loans or other rights by the Association for the period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the Association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

G. A deposit in this state, held pursuant to law or required by the Commissioner for the benefit of creditors, including but not limited to policy or contract owners, not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of a member insurer domiciled in this state or in a reciprocal state, shall be promptly paid by the Association. The Association shall be entitled to retain a portion of any amount so paid to it equal to the percentage determined by dividing the aggregate amount of policy or contract owners claims related to that insolvency for which the Association has provided statutory benefits by the aggregate amount of all claims by the policy or contract owners in this state related to that insolvency and shall remit to the domiciliary receiver the amount so paid to the Association less the amount retained pursuant to this subsection. Any amount so paid to the Association and retained by it shall be treated as a distribution of estate assets pursuant to applicable state receivership laws dealing with early access disbursements.

H. If the Association fails to act within a reasonable period of time with respect to an insolvent insurer, as provided in subsection B of this section, the Commissioner shall have the powers and duties of the Association under the Oklahoma Life and Health Insurance Guaranty Association Act with respect to the insolvent insurer.

I. The Association may render assistance and advice to the Commissioner, upon the request of the Commissioner, concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of an impaired or insolvent insurer.

J. The Association shall have standing to appear or intervene before a court or agency in this state which has jurisdiction over an impaired or insolvent insurer concerning which the Association is or may become obligated under the Oklahoma Life and Health Insurance

Guaranty Association Act or with jurisdiction over any person or property against which the Association may have rights through subrogation or otherwise. Standing shall extend to all matters germane to the powers and duties of the Association including, but not limited to, proposals for reinsuring, reissuing, modifying or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The Association shall also have the right to appear or intervene before a court or agency in another state with jurisdiction over an impaired or insolvent insurer for which the Association is or may become obligated or with jurisdiction over any person or property against whom the Association may have rights through subrogation or otherwise.

K. 1. Any person receiving benefits under the Oklahoma Life and Health Insurance Guaranty Association Act shall be deemed to have assigned the rights under, and any causes of action against any person for losses arising under, resulting from or otherwise relating to, the covered policy or contract to the Association to the extent of the benefits received because of this act, whether the benefits are payments of or on account of contractual obligations, continuation of coverage or provision of substitute or alternative policies, contracts or coverages. The Association may require an assignment to it of the rights and cause of action by any enrollee, payee, policy or contract owner, beneficiary, insured or annuitant as a condition precedent to the receipt of any rights or benefits conferred by this act upon the person.

2. The subrogation rights of the Association under this subsection shall have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under the Oklahoma Life and Health Insurance Guaranty Association Act.

3. In addition to paragraphs 1 and 2 of this subsection, the Association shall have all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary, enrollee or payee of a policy or contract with respect to the policy or contracts, including without limitation, in the case of a structured settlement annuity, any rights of the owner, beneficiary or payee of the annuity, to the extent of benefits received pursuant to the Oklahoma Life and Health Insurance Guaranty Association Act, against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment therefor, excepting any person responsible solely by reason of serving as an assignee in respect of a qualified assignment under Internal Revenue Code Section 130.

4. If paragraphs 1 through 3 of this subsection are invalid or ineffective with respect to any person or claim for any reason, the

amount payable by the Association with respect to the related covered obligations shall be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies or contracts, or portion thereof, covered by the Association.

5. If the Association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the Association has rights as described in paragraphs 1 through 4 of this subsection, the person shall pay to the Association the portion of the recovery attributable to the policies or contracts, or portion thereof, covered by the Association.

L. In addition to the rights and powers specified in the Oklahoma Life and Health Insurance Guaranty Association Act, the Association may:

1. Enter into contracts as are necessary or proper to carry out the provisions and purposes of the Oklahoma Life and Health Insurance Guaranty Association Act;

2. Sue or be sued, including, but not limited to, taking any legal actions necessary or proper to recover any unpaid assessments under Section 2030 of this title and to settle claims or potential claims against it;

3. Borrow money to effect the purposes of the Oklahoma Life and Health Insurance Guaranty Association Act. Any notes or other evidence of indebtedness of the Association not in default shall be legal investments for domestic member insurers and may be carried as admitted assets;

4. Employ or retain persons as are necessary or appropriate to handle the financial transactions of the Association, and to perform other functions as become necessary or proper under the Oklahoma Life and Health Insurance Guaranty Association Act;

5. Take any legal action as may be necessary or appropriate to avoid or recover payment of improper claims;

6. Exercise, for the purposes of the Oklahoma Life and Health Insurance Guaranty Association Act and to the extent approved by the Commissioner, the powers of a domestic life insurer, health insurer or health maintenance organization, but in no case may the Association issue policies or contracts other than those issued to perform its obligations under the Oklahoma Life and Health Insurance Guaranty Association Act;

7. Organize itself as a corporation or in other legal form permitted by the laws of the state;

8. Request information from a person seeking coverage from the Association in order to aid the Association in determining its obligations under the Oklahoma Life and Health Insurance Guaranty Association Act with respect to the person, and the person shall promptly comply with the request;

9. Unless prohibited by law, in accordance with the terms and conditions of the policy or contract, file for actuarially justified rate or premium increases for any policy or contract for which it provides coverage under the Oklahoma Life and Health Insurance Guaranty Association Act; and

10. Take other necessary or appropriate action to discharge its duties and obligations under the Oklahoma Life and Health Insurance Guaranty Association Act or to exercise its powers under the Oklahoma Life and Health Insurance Guaranty Association Act.

M. The Association may join an organization of one or more other state associations of similar purposes, to further the purposes and administer the powers and duties of the Association.

N. 1. a. At any time within one hundred eighty (180) days of the date of the order of liquidation, the Association may elect to succeed to the rights and obligations of the ceding member insurer that relate to policies, contracts or annuities covered, in whole or in part, by the Association, in each case under any one or more reinsurance contracts entered into by the insolvent insurer and its reinsurers and selected by the Association. Any assumption shall be effective as of the date of the order of liquidation. The election shall be effected by the Association or the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) on its behalf sending written notice, return receipt requested, to the affected reinsurers.

b. To facilitate the earliest practicable decision about whether to assume any of the contracts of reinsurance, and in order to protect the financial position of the estate, the receiver and each reinsurer of the ceding member insurer shall make available upon request to the Association or to NOLHGA on its behalf as soon as possible after commencement of formal delinquency proceedings, copies of in-force contracts of reinsurance and all related files and records relevant to the determination of whether the contracts should be assumed, and notices of any defaults under the reinsurance contracts or any known event or condition which with the passage of time could become a default under the reinsurance contracts.

c. The requirements provided in this subparagraph shall apply to reinsurance contracts assumed by the Association:

(1) the Association shall be responsible for all unpaid premiums due under the reinsurance contracts for periods both before and after the

- date of the order of liquidation, and shall be responsible for the performance of all other obligations to be performed after the date of the order of liquidation, in each case which relate to policies, contracts or annuities covered, in whole or in part, by the Association. The Association may charge policies, contracts or annuities covered in part by the Association, through reasonable allocation methods, the costs for reinsurance in excess of the obligations of the Association and shall provide notice and an accounting of these charges to the liquidator,
- (2) the Association shall be entitled to any amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods after the date of the order of liquidation and that relate to policies, contracts or annuities covered, in whole or in part, by the Association, provided that, upon receipt of any of these amounts, the Association shall be obliged to pay to the beneficiary under the policy, contract or annuity on account of which the amounts were paid a portion of the amount equal to the lesser of:
- (a) the amount received by the Association, or
 - (b) the excess of the amount received by the Association over the amount equal to the benefits paid by the Association on account of the policy, contract or annuity less the retention of the insurer applicable to the loss or event,
- (3) within thirty (30) days following the election date of the Association, the Association and each reinsurer under contracts assumed by the Association shall calculate the net balance due to or from the Association under each reinsurance contract as of the election date with respect to policies, contracts or annuities covered, in whole or in part, by the Association, which calculation shall give full credit to all items paid by either the member insurer or its receiver or the reinsurer prior to the election date. The reinsurer shall pay the receiver any amounts due for losses or events prior to the date of the order of liquidation, subject to any set-off for premiums unpaid for periods prior to the date, and the Association or reinsurer shall pay any

remaining balance due the other, in each case within five (5) days of the completion of the aforementioned calculation. Any disputes over the amounts due to either the Association or the reinsurer shall be resolved by arbitration pursuant to the terms of the affected reinsurance contracts or, if the contract contains no arbitration clause, as otherwise provided by law. If the receiver has received any amounts due the Association pursuant to division (2) of this subparagraph, the receiver shall remit the same to the Association as promptly as practicable, and

- (4) if the Association or receiver, on the behalf of the Association, within sixty (60) days of the election date, pays the unpaid premiums due for periods both before and after the election date that relate to policies, contracts or annuities covered, in whole or in part, by the Association, the reinsurer shall not be entitled to terminate the reinsurance contracts for failure to pay the premium insofar as the reinsurance contracts relate to policies, contracts or annuities covered, in whole or in part, by the Association, and shall not be entitled to set off any unpaid amounts due under other contracts, or unpaid amounts due from parties other than the Association, against amounts due the Association.

2. During the period from the date of the order of liquidation until the election date, or if the election date does not occur, until one hundred eighty (180) days after the date of the order of liquidation:

- a.
 - (1) neither the Association nor the reinsurer shall have any rights or obligations under reinsurance contracts that the Association has the right to assume under paragraph 1 of this subsection, whether for periods prior to or after the date of the order of liquidation, and
 - (2) the reinsurer, the receiver and the Association shall, to the extent practicable, provide each other data and records reasonably requested.
- b. Provided that once the Association has elected to assume a reinsurance contract, the rights and obligations of the parties shall be governed by paragraph 1 of this subsection.

3. If the Association does not elect to assume a reinsurance contract by the election date pursuant to paragraph 1 of this

subsection, the Association shall have no rights or obligations, in each case for periods both before and after the date of the order of liquidation, with respect to the reinsurance contract.

4. When policies, contracts or annuities, or covered obligations with respect thereto, are transferred to an assuming insurer, reinsurance on the policies, contracts or annuities may also be transferred by the Association, in the case of contracts assumed under paragraph 1 of this subsection, subject to the following:

- a. unless the reinsurer and the assuming insurer agree otherwise, the reinsurance contract transferred shall not cover any new policies, contracts of insurance or annuities in addition to those transferred,
- b. the obligations described in paragraph 1 of this subsection shall no longer apply with respect to matters arising after the effective date of the transfer, and
- c. notice shall be given in writing, return receipt requested, by the transferring party to the affected reinsurer not less than thirty (30) days prior to the effective date of the transfer.

5. The provisions of this subsection shall govern any affected reinsurance contract that provides for or requires any payment of reinsurance proceeds, on account of losses or events that occur in periods after the date of the order of liquidation, to the receiver of the insolvent insurer or any other person. The receiver shall remain entitled to any amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods prior to the date of the order of liquidation, subject to applicable setoff provisions.

6. Except as otherwise provided in this section, nothing in this subsection shall alter or modify the terms and conditions of any reinsurance contract. Nothing in this section shall abrogate or limit any rights of any reinsurer to claim that it is entitled to rescind a reinsurance contract. Nothing in this section shall give a policyholder, contract owner, enrollee, certificate holder or beneficiary an independent cause of action against a reinsurer that is not otherwise set forth in the reinsurance contract. Nothing in this section shall limit or affect the rights of the Association as a creditor of the estate against the assets of the state. Nothing in this section shall apply to reinsurance agreements covering property or casualty risks.

0. The Board of Directors of the Association shall have discretion and may exercise reasonable business judgment to determine the means by which the Association is to provide the benefits of the Oklahoma Life and Health Insurance Guaranty Association Act in an economical and efficient manner.

P. Where the Association has arranged or offered to provide the benefits of the Oklahoma Life and Health Insurance Guaranty Association Act to a covered person under a plan or arrangement that fulfills the obligations of the Association under the Oklahoma Life and Health Insurance Guaranty Association Act, the person shall not be entitled to benefits from the Association in addition to or other than those provided under the plan or arrangement.

Q. Venue in a suit against the Association arising under the Oklahoma Life and Health Insurance Guaranty Association Act shall be in Oklahoma County. The Association shall not be required to give an appeal bond in an appeal that relates to a cause of action arising under the Oklahoma Life and Health Insurance Guaranty Association Act.

R. In carrying out its duties in connection with guaranteeing, assuming or reinsuring policies or contracts under subsection A or B of this section, the Association may, subject to approval of the receivership court, issue substitute coverage for a policy or contract that provides an interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with the following provisions:

1. In lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for:

- a. a fixed interest rate,
- b. payment of dividends with minimum guarantees, or
- c. a different method for calculating interest or changes in value;

2. There is no requirement for evidence of insurability, waiting period or other exclusion that would not have applied under the replaced policy or contract; and

3. The alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms.

Added by Laws 1981, c. 133, § 8. Amended by Laws 1987, c. 177, § 4, eff. Nov. 1, 1987; Laws 2010, c. 145, § 3, eff. Nov. 1, 2010; Laws 2019, c. 384, § 7, eff. Nov. 1, 2019.

§36-2029. Repealed by Laws 2010, c. 145, § 8, eff. Nov. 1, 2010.

§36-2030. Assessments.

A. For the purpose of providing the funds necessary to carry out the powers and duties of the Oklahoma Life and Health Insurance Guaranty Association, the Board of Directors of the Oklahoma Life and Health Insurance Guaranty Association shall assess the member insurers, separately for each account, at such time and for such amounts as the Board finds necessary. Assessments shall be due not

less than thirty (30) days after prior written notice to the member insurers and shall accrue interest at six percent (6%) per annum on and after the due date.

B. There shall be two classes of assessments, as follows:

1. Class A assessments shall be made for the purpose of meeting administrative and legal costs and other expenses and examinations. Class A assessments may be made whether or not related to a particular impaired or insolvent insurer;

2. Class B assessments shall be made to the extent necessary to carry out the powers and duties of the Association under Section 2028 of this title with regard to an impaired or an insolvent foreign or domestic insurer.

C. 1. The amount of any Class A assessment shall be determined by the Board and may be made on a pro rata or non-pro rata basis. If pro rata, the Board may provide that it be credited against future Class B assessments. A non-pro rata assessment shall be credited against future insolvency.

The amount of any Class B assessment, except for assessments related to long-term care insurance, shall be allocated for assessment purposes among the accounts and among the subaccounts of the life insurance and annuity account, pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the Board in its sole discretion as being fair and reasonable under the circumstances.

The amount of the Class B assessment for long-term care insurance written by the impaired or insolvent insurer shall be allocated according to a methodology included in the plan of operation and approved by the Commissioner. The methodology shall provide for fifty percent (50%) of the assessment to be allocated to accident and health member insurers and fifty percent (50%) to be allocated to life and annuity member insurers.

2. Class B assessments against member insurers for each account shall be in the proportion that the premiums received on business in this state by each assessed member insurer on policies or contracts covered by each account for the three (3) most recent calendar years for which information is available preceding the year in which the member insurer became impaired or insolvent, as the case may be, bears to such premiums received on business in this state for such calendar years by all assessed member insurers.

3. Assessments for funds to meet the requirements of the Association with respect to an impaired or insolvent insurer shall not be made until necessary to implement the purposes of this act. Classification of assessments under subsection B of this section and computation of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible.

D. The Association may abate, or defer in whole or in part, the assessment of a member insurer if, in the opinion of the Board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section.

E. The total of all assessments upon a member insurer for each account in any one (1) calendar year shall not exceed two percent (2%) of such average premiums of the insurer received in this state during the three (3) calendar years preceding the assessment on the policies and contracts covered by the account and in which the member insurer became an impaired or insolvent insurer. If the maximum assessment together with the other assets of the Association in any account does not provide in any one (1) year in either account an amount sufficient to carry out the responsibilities of the Association, the necessary additional funds shall be assessed as soon thereafter as permitted by the Oklahoma Life and Health Insurance Guaranty Association Act. The Board may provide in the plan of operation, a method of allocating funds among claims, whether relating to one or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

F. The Board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contributions of each insurer to that account, the amount by which the assets of the account exceed the amount the Board finds is necessary to carry out the obligations of the Association during the coming year with regard to that account, including assets accruing from assignment, subrogation, net realized gains and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the Association and for future losses.

G. It shall be proper for any member insurer to consider the amount reasonably necessary to meet its obligations under this act in determining its premium rates and policy owner dividends as to any kind of insurance or health maintenance organization business within the scope of the Oklahoma Life and Health Insurance Guaranty Association Act.

H. The Association shall issue to each member insurer paying an assessment under the Oklahoma Life and Health Insurance Guaranty Association Act, other than a Class A assessment, a certificate of contribution, in a form prescribed by the Commissioner, for the amount of the assessment so paid. All outstanding certificates shall be of equal priority without reference to amounts or dates of

issue. A certificate of contribution may be shown by the member insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the Commissioner may approve.

I. A member insurer may offset against its premium, franchise or income tax liability to this state, an assessment described in subsection H of this section to the extent of twenty percent (20%) of the amount of such assessment for each of the five (5) calendar years following the year in which such assessment was paid. In the event a member insurer should cease doing business, all uncredited assessments may be credited against its premium, franchise or income tax liability for the year it ceases doing business.

J. Any sums acquired by refund, pursuant to subsection F of this section, from the Association which have theretofore been written off by contributing insurers and offset against premium, franchise or income taxes as provided in subsection I of this section, and are not then needed for purposes of the Oklahoma Life and Health Insurance Guaranty Association Act, shall be paid by the Association to the Insurance Commissioner who shall dispense such funds in accordance with the statutes regarding disbursement of such taxes.

Added by Laws 1981, c. 133, § 10. Amended by Laws 1985, c. 328, § 19, emerg. eff. July 29, 1985; Laws 1987, c. 177, § 6, eff. Nov. 1, 1987; Laws 1989, c. 181, § 7, eff. Nov. 1, 1989; Laws 2019, c. 384, § 8, eff. Nov. 1, 2019.

§36-2031. Commissioner - Powers and duties.

A. In addition to the duties and powers enumerated elsewhere in this act, the Commissioner shall:

1. Upon request of the Board, provide the Association with a statement of the premiums in the appropriate states for each member insurer;

2. When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time. Notice to the impaired insurer shall constitute notice to its shareholders, if any. The failure of the insurer to promptly comply with such demand shall not excuse the Association from the performance of its powers and duties under this act.

If a foreign or alien member insurer is subject to a liquidation proceeding in its domiciliary jurisdiction or state of entry, the Commissioner shall be appointed conservator or shall be permitted to initiate an ancillary receivership.

B. The Commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance business in this state of any member insurer which fails to pay an assessment when due or fails to comply with the procedural rules. As an

alternative, the Commissioner may levy a forfeiture on any member insurer which fails to pay an assessment when due. Such forfeiture shall not exceed five percent (5%) of the unpaid assessment per month, but no forfeiture shall be less than One Hundred Dollars (\$100.00) per month.

C. Any action of the Board or the Association may be appealed to the Commissioner by any member insurer if such appeal is taken within thirty (30) days of the action of the Board or Association. Any final action or order of the Commissioner shall be subject to judicial review in a court of competent jurisdiction.
Amended by Laws 1987, c. 175, § 20, eff. Nov. 1, 1987.

§36-2032. Detection and prevention of insurer insolvencies.

A. To aid in the detection and prevention of member insurer insolvencies, it shall be the duty of the Insurance Commissioner:

1. To notify the commissioners of all of the other states, territories of the United States and the District of Columbia within thirty (30) days following the action taken or the date the action occurs, when the Commissioner takes any of the following actions against a member insurer:

- a. revocation of license,
- b. suspension of license, or
- c. makes a formal order that the member insurer restrict its premium writing, obtain additional contributions to surplus, withdraw from the state, reinsure all or any part of its business, or increase capital, surplus or any other account for the security of policy owners, contract owners, certificate owners or creditors;

2. To report to the board of directors when the Commissioner has taken any of the actions set forth in paragraph 1 of this subsection or has received a report from any other commissioner of other states indicating that any action has been taken in another state. The report to the board of directors shall contain all significant details of the action taken or the report received from a commissioner from another state;

3. To report to the board when the Commissioner has reasonable cause to believe from an examination, whether completed or in process, of any member insurer that the insurer may be an impaired or insolvent insurer;

4. To furnish to the board of directors the National Association of Insurance Commissioners (NAIC) Insurance Regulatory Information System (IRIS) ratios and listings of companies not included in the ratios developed by the NAIC, and the board may use the information contained therein in carrying out its duties and responsibilities under this section. The report and the information contained therein shall be kept confidential by the board of

directors until a time as made public by the Commissioner or other lawful authority.

B. The Commissioner may seek the advice and recommendations of the board of directors of the Oklahoma Life and Health Insurance Guaranty Association concerning any matter affecting the duties and responsibilities of the Commissioner regarding the financial condition of member insurers and health maintenance organizations seeking admission to transact business in this state.

C. The board of directors may, upon majority vote, make reports and recommendations to the Commissioner upon any matter germane to the solvency, liquidation, rehabilitation or conservation of any member insurer or germane to the solvency of any member insurer or health maintenance organization seeking to do business in this state. The reports and recommendations shall not be considered public documents.

D. The board of directors may, upon majority vote, notify the Commissioner of any information indicating a member insurer may be an impaired or insolvent insurer.

E. The board of directors may, upon majority vote, make recommendations to the Commissioner for the detection and prevention of member insurer insolvencies.

Added by Laws 1981, c. 133, § 12. Amended by Laws 2010, c. 145, § 4, eff. Nov. 1, 2010; Laws 2019, c. 384, § 9, eff. Nov. 1, 2019.

§36-2033. Repealed by Laws 2010, c. 145, § 8, eff. Nov. 1, 2010.

§36-2034. Unpaid assessments of impaired or insolvent insurer.

Nothing in this act shall be construed to reduce the liability for unpaid assessments of the insureds on an impaired or insolvent insurer operating under a plan with assessment liability.

Laws 1981, c. 133, § 14.

§36-2035. Records of negotiations and meetings.

Records shall be kept of all negotiations and meetings in which the Association or its representatives are involved, to discuss the activities of the Association in carrying out its powers and duties under Sections 8 and 9 of this act. Records of such negotiations or meetings shall be made public only upon the termination of a liquidation, rehabilitation, receivership or conservatorship proceeding involving the impaired or insolvent insurer, upon the termination of the impairment or insolvency of the insurer, or upon an order of a court of competent jurisdiction. Nothing in this section shall limit the duty of the Association to render a report of its activities under Section 19 of this act.

Laws 1981, c. 133, § 15.

§36-2036. Assets of impaired or insolvent insurer - Association as creditor - Payment of policies and contractual obligations.

A. For the purpose of carrying out its obligations under the Oklahoma Life and Health Insurance Guaranty Association Act, the Oklahoma Life and Health Insurance Guaranty Association shall be deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the Association is entitled as subrogee pursuant to subsection K of Section 2028 of this title. Assets of the impaired or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by the Oklahoma Life and Health Insurance Guaranty Association Act. Assets attributable to covered policies or contracts, as used in this subsection, are that proportion of the assets that the reserves which should have been established for such policies or contracts bear to the reserves which should have been established for all policies of insurance or health benefit plans written by the impaired or insolvent insurer.

B. As a creditor of the impaired or insolvent insurer as established in subsection A of this section and consistent with Section 1927.1 of this title, the Association and other similar associations shall be entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the assets become available to reimburse it, as a credit against contractual obligations under this act. If the liquidator has not, within one hundred twenty (120) days of a final determination of insolvency of a member insurer by the receivership court, made an application to the court for the approval of a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvency, then the Association shall be entitled to make application to the receivership court for approval of its own proposal to disburse these assets.

Added by Laws 1981, c. 133, § 16. Amended by Laws 2010, c. 145, § 5, eff. Nov. 1, 2010; Laws 2019, c. 384, § 10, eff. Nov. 1, 2019.

§36-2037. Distribution of ownership rights of impaired or insolvent insurer.

A. Prior to the termination of any liquidation, rehabilitation, receivership or conservatorship proceeding, the court may take into consideration the contributions of the respective parties, including the Association, the shareholders and the policyowners of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of such insolvent insurer. In such a determination, consideration shall be given to the welfare of the policyholders of the continuing or successor insurer.

B. No distribution to stockholders, if any, of an impaired or insolvent insurer shall be made until and unless the total valid claims of the Association for funds expended in carrying out its powers and duties under Section 8 of this act with respect to such insurer have been fully recovered by the Association.
Laws 1981, c. 133, § 17.

§36-2038. Recovery of distribution of insurer - Limitations.

A. If an order for liquidation or rehabilitation of a member insurer domiciled in this state has been entered, the receiver appointed under such order shall have a right to recover on behalf of the member insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the member insurer on its capital stock, made at any time during the five (5) years preceding the petition for liquidation or rehabilitation subject to the limitations of subsections B through D of this section.

B. No such dividend shall be recoverable if the member insurer shows that when paid the distribution was lawful and reasonable, and that the member insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the member insurer to fulfill its contractual obligations.

C. Any person who was an affiliate that controlled the member insurer at the time the distributions were paid shall be liable up to the amount of distributions he received. Any person who was an affiliate that controlled the member insurer at the time the distributions were declared shall be liable up to the amount of distributions he would have received if they have been paid immediately. If two persons are liable with respect to the same distributions, they shall be jointly and severally liable.

D. The maximum amount recoverable under this subsection shall be the amount needed in excess of all other available assets of the insolvent insurer to pay the contractual obligations of the insolvent insurer.

E. If any person liable under subsection C of this section is insolvent, all its affiliates that controlled it at the time the dividend was paid shall be jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

Added by Laws 1981, c. 133, § 18. Amended by Laws 2019, c. 384, § 11, eff. Nov. 1, 2019.

§36-2039. Examination and regulation of Association - Reports.

The Association shall be subject to examination and regulation by the Commissioner. The Board shall submit to the Commissioner, not later than May 1 of each year, a financial report for the preceding

calendar year in a form approved by the Commissioner and a report of its activities during the preceding calendar year.
Laws 1981, c. 133, § 19.

§36-2040. Exemption from taxes and fees.

The Association shall be exempt from payment of all fees and all taxes levied by this state or any of its subdivisions, except taxes levied on real property.
Laws 1981, c. 133, § 20.

§36-2041. Certain persons exempted from liability.

There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer or its agents or employees, the Association or its agents or employees, members of the Board, or the Commissioner or his representatives, for any action or omission by them in the performance of their official powers and duties under this act. Such immunity shall extend to the participation in any organization of one or more other state associations of similar purposes and to any such organization and its agents or employees.

Amended by Laws 1987, c. 177, § 7, eff. Nov. 1, 1987.

§36-2042. Stay of other proceedings - Judgments may be set aside.

All proceedings in which the insolvent insurer is a party in any court in this state shall be stayed one hundred eighty (180) days from the date an order of liquidation, rehabilitation or conservation is final to permit proper legal action by the Oklahoma Life and Health Insurance Guaranty Association on any matters germane to its powers or duties. As to judgment under any decision, order, verdict or finding based on default, the Association may apply to have the judgment set aside by the same court that made the judgment and shall be permitted to defend against the suit on the merits.

Added by Laws 1981, c. 133, § 22. Amended by Laws 2010, c. 145, § 6, eff. Nov. 1, 2010.

§36-2043. Advertising prohibited - Exemptions - Preparation of summary document - Disclaimer - Notice of noncoverage.

A. No person, including a member insurer, agent or affiliate of a member insurer, shall make, publish, disseminate, circulate or place before the public, or cause directly or indirectly to be made, published, disseminated, circulated or placed before the public, in any newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio station or television station, or in any other way, any advertisement, announcement or statement which uses the existence of the Oklahoma Life and Health Insurance Guaranty Association of this

state for the purpose of sales, solicitation or inducement to purchase any form of insurance or other coverage covered by the Oklahoma Life and Health Insurance Guaranty Association Act. Provided, however, that this section shall not apply to the Oklahoma Life and Health Insurance Guaranty Association or any other entity which does not sell or solicit insurance or coverage by a health maintenance organization.

B. The Association shall have a summary document describing the general purposes and current limitations of the Association and complying with subsection C of this section. This document shall have been submitted to, and approved by, the Insurance Commissioner. Sixty (60) days after receiving such approval, no member insurer shall deliver a policy or contract described in paragraph 1 of subsection B of Section 2025 of this title to a policy owner, contract owner, certificate holder or enrollee unless the document is delivered to the policy or contract holder prior to or at the time of delivery of the policy or contract, except if subsection D of this section applies. The document should also be available upon request by a policy owner, contract owner, certificate holder or enrollee. The distribution, delivery or contents or interpretation of this document shall not mean that either the policy or the contract or the holder thereof would be covered in the event of impairment or insolvency of a member insurer. The description document shall be revised by the Association as amendments to the act may require. Failure to receive this document does not give the policyholder, contract holder, certificate holder, enrollee or insured any greater rights than those stated in this act.

C. The document prepared under subsection B of this section shall contain a clear and conspicuous disclaimer on its face. The Commissioner shall promulgate a rule establishing the form and content of the disclaimer. The disclaimer shall:

1. State the name and address of the life and health insurance guaranty association and insurance department;

2. Prominently warn the policy owner, contract owner, certificate holder or enrollee that the Life and Health Insurance Guaranty Association may not cover the policy or contract or, if coverage is available, it will be subject to substantial limitations, exclusions and conditioned on continued residence in the state;

3. State that the member insurer and its agents are prohibited by law from using the existence of the Oklahoma Life and Health Insurance Guaranty Association for the purpose of sales, solicitation or inducement to purchase any form of insurance or health maintenance organization coverage;

4. Emphasize that the policy or contract holder should not rely on coverage under the Oklahoma Life and Health Insurance Guaranty Association when selecting an insurer;

5. Provide other information as directed by the Commissioner.

D. No insurer or agent may deliver a policy or contract described in paragraph 1 of subsection B of Section 2025 of this title, but excluded under subparagraph a of paragraph 2 of subsection B of Section 2025 of this title from coverage under the Oklahoma Life and Health Insurance Guaranty Association Act, unless the insurer or agent, prior to or at the time of delivery, gives the policy owner, contract owner, certificate holder or enrollee a separate written notice which clearly and conspicuously discloses that the policy or contract is not covered by the Life and Health Insurance Guaranty Association. The Commissioner shall by rule specify the form and content of the notice.

Added by Laws 1981, c. 133, § 23. Amended by Laws 1987, c. 177, § 8, eff. Nov. 1, 1987; Laws 2019, c. 384, § 12, eff. Nov. 1, 2019.

§36-2044. Exemption.

None of the amendatory provisions contained herein shall apply to any member insurer that is impaired or insolvent on the date such amendments become effective.

Added by Laws 2010, c. 145, § 7, eff. Nov. 1, 2010.

§36-2101. Scope of article.

A. This article shall apply to domestic stock insurers and domestic mutual insurers only except that it shall not apply to farmers' mutual fire insurance associations organized under Article 28 of this Code, to any association organized under the supervision or by authority of any legally incorporated Grange Order of Patrons of Husbandry, or to the Oklahoma State Union of the Farmer's Educational and Cooperative Union of America, when such association is formed for the mutual benefit of the members of such order or orders exclusively.

Subsection B of Section 2115 and subsection C of Section 2119 of this article shall apply also to foreign and alien mutual insurers.

B. Any domestic stock or mutual insurer which as of April 1, 1957, had duly filed its articles of incorporation and was lawfully in process of completing its organization, shall complete its organization according to such procedures as were provided by laws in force immediately prior to the effective date of this Code.

Any other domestic stock or mutual insurer in process of organization on the effective date of this Code shall be governed by such provisions of this article as the Insurance Commissioner deems to be practicably applicable, and otherwise according to laws in force immediately prior to such effective date.

C. Existing domestic stock and mutual insurers are governed by the applicable provisions of this article.

Laws 1957, p. 303, § 2101.

§36-2102. "Stock" insurer defined.

A "stock" insurer is an incorporated insurer with capital divided into shares and owned by its shareholders.

Laws 1957, p. 304, § 2102.

§36-2103. "Mutual" insurer defined.

A "mutual" insurer is an incorporated insurer without capital stock or shares, and is owned by its policyholders.

Laws 1957, p. 304, § 2103.

§36-2104. Misleading names.

No such name shall be adopted by such corporation which is so similar to any name already in use by any such existing corporation, company or association, organized or doing business in this state, as to be confusing or misleading.

Laws 1957, p. 304, § 2104.

§36-2105. Articles of incorporation; contents.

A. This section applies to stock and mutual insurers hereafter incorporated in Oklahoma.

B. Five or more individuals of age of twenty-one (21) years or more may incorporate a stock insurer; ten or more such individuals may incorporate a mutual insurer. Not less than two-thirds (2/3) of the incorporators shall be citizens of the United States residing in Oklahoma. The articles of incorporation shall be signed and acknowledged by the incorporators as deeds are required to be acknowledged.

C. The articles of incorporation shall state:

1. The name of the corporation; if a mutual, the word "mutual" shall be a part of the name;

2. The duration of its existence, which may be perpetual;

3. The kinds of insurance the corporation is formed to transact, according to the definitions thereof in this Code;

4. If a stock corporation, its authorized capital, the classes and number of shares into which divided, the par value of each such share, and the respective rights of each such class. Shares without par value shall not be authorized;

5. If a mutual corporation, the maximum contingent liability of its members, other than as to nonassessable policies, for payment of losses and expenses incurred, which liability shall be as stated in the articles of incorporation but not less than one nor more than six times the premium for the member's policy at the annual premium rate for a term of one (1) year;

6. The number of directors, of which there shall be not less than three nor more than fifty, who shall conduct the affairs of the corporation, and the names and addresses of the corporation's first directors and officers for stated terms of office of not less than

two (2) months nor more than one (1) year; provided, however, that the Insurance Commissioner may approve amended articles of incorporation for a domestic insurer to permit the board of directors to consist of three or more directors;

7. The city or town in Oklahoma in which is to be located the principal place of business, and the counties, states, and countries in which business may be transacted;

8. The limitations, if any, on the corporation's indebtedness;

9. If a stock corporation, the extent, if any, to which stock of the corporation shall be liable to assessment;

10. Such other provisions, not inconsistent with law, as deemed appropriate by the incorporators;

11. The names and addresses of the incorporators; and

12. The name and address of the person in Oklahoma upon whom all process in any action or proceeding may be served. Such designation may be changed or amended on authority of the Board of Directors evidenced by the filing of a certificate stating such change, executed by the President, attested by the Secretary, and filed with the Insurance Commissioner.

Added by Laws 1957, p. 304, § 2105. Amended by Laws 1997, c. 273, § 5, eff. July 1, 1997; Laws 1997, c. 418, § 91, eff. Nov. 1, 1997.

§36-2106. Corporate powers granted; general powers and duties.

Every corporation organized under the provisions of this act may, in its corporate name, sue and be sued; and shall have power to make contracts of insurance, indemnity or suretyship with any person, government or governmental agency, state or political subdivision thereof, public or private corporation, board, association, firm, estate, trustee or fiduciary in this state or elsewhere; to prescribe the qualifications and the manner and form of the admission or withdrawal of members; to have and use a common seal which may be changed or altered at pleasure; to be capable in its corporate name, or in the name of trustee chosen by the board of directors, to take, purchase, lease, hold and dispose of real or personal property for carrying into effect the purpose of the corporation; to make all necessary rules and regulations concerning the hazards incurred, the premium rates to be used, and adjustment and payment of losses; to fix the compensation of its directors and officers and require bond for the faithful performance of their duties; to exercise all such other powers as may be necessary to effect the object of such corporation, subject to the restrictions herein provided; to make or amend bylaws not inconsistent with law or the provisions of the articles of association, which bylaws shall fix the date and place of the annual meeting of members, shall designate the number of directors, which shall be not less than five, define the duties of the officers and fix the term of office of the directors and officers of such company, and make all further

necessary provisions concerning the conduct of its business or affairs.

Laws 1957, p. 304, § 2106.

§36-2107. Filing of articles; issuance of certificate.

A. The articles of incorporation shall be filed in the office of the Secretary of State, and certified copies thereof shall be filed with the Insurance Commissioner. Articles of incorporation shall be approved by the Insurance Commissioner before they are filed in the office of the Secretary of State. After January 1, 1970, the Insurance Commissioner shall not approve or renew any articles of incorporation which provide for the issuance of shares of common capital stock to any shareholder unless such shareholder shall be entitled at the shareholders meetings to one vote for each share standing in the name of such shareholder in the books of the corporation.

B. Upon completion of such filing as to the articles of incorporation, the Secretary of State shall issue to the corporation a certificate of incorporation. Such corporation shall not transact business as an insurer until it has applied for and received from the Commissioner a certificate of authority as provided by this Code.

Laws 1957, p. 305, § 2107; Laws 1969, c. 289, § 2; Laws 1970, c. 109, § 2, emerg. eff. April 1, 1970.

§36-2108. Amendment of articles.

A. The articles of incorporation of a stock insurer increasing or reducing authorized capital or for other purposes may be amended in accordance with the general laws of Oklahoma applying to corporations formed for profit. No amendment shall reduce authorized capital below the amount required by this Code for the kinds of insurance thereafter to be transacted.

B. The articles of incorporation of a mutual insurer may be amended by the affirmative vote of two-thirds (2/3) of its members present in person or by proxy at a regular or special meeting of members of which notice in writing setting forth the proposed amendment was mailed to all members at least thirty (30) days in advance. A certificate of the amendments, signed and acknowledged by the president and attested by the secretary of the corporation shall be filed with the Commissioner and the Secretary of State.

Laws 1957, p. 305, § 2108.

§36-2109. Applications for insurance in formation of mutual insurers.

A. Upon issuance of its certificate of incorporation as provided in subsection B of Section 2107 of this article, the directors and officers of a domestic mutual corporation formed for

the purpose of becoming a mutual insurer may open books for the registration of such requisite applications for insurance policies as they may accept, and may receive deposits of premiums thereon.

B. All such applications shall be in writing signed by the applicant, covering subjects of insurance resident, located, or to be performed in Oklahoma.

C. All such applications shall provide that:

1. Issuance of the policy is contingent upon completion of organization of the insurer and issuance to it of a proper certificate of authority.

2. No insurance is provided until the certificate of authority has been so issued; and

3. The prepaid premium or deposit, and membership or policy fee, if any, shall be refunded in full to the applicant if the organization is not completed and certificate of authority issued before a specified reasonable date, which date shall be not later than one (1) year following date of issuance of the certificate of incorporation.

D. All qualifying premiums collected shall be in cash.

E. Solicitation for such qualifying applications for insurance shall be by licensed agents of the corporation, and the Commissioner shall upon application therefor issue temporary agent's licenses expiring on the date specified pursuant to paragraph 3, subsection B, above, to individuals appointed by the corporation and qualified as for a resident agent's license except as to the taking of an examination. The Commissioner may suspend or revoke any such license for any of the same causes and pursuant to the same procedures as are applicable to suspension or revocation of licenses of agents in general under article 13.

Laws 1957, p. 305, § 2109; Laws 1965, c. 60, § 15, eff. July 1, 1965.

§36-2110. Formation of mutuals; trust deposit of premiums; issuance of policies.

A. All sums collected by a domestic mutual corporation as premiums and fees on qualifying applications for insurance therein shall be deposited in trust in an Oklahoma bank or trust company under a written agreement consistent with this section and with paragraph 3 of subsection C of Section 2109 of this article. The corporation shall file an executed copy of such trust agreement with the Commissioner.

B. Upon issuance to the corporation of a certificate of authority as an insurer for the kind of insurance for which such applications were solicited, all funds so held in trust shall become the funds of the insurer, and the insurer shall forthwith issue and deliver its policies for which premiums had been paid and accepted.

The insurance provided by such policies shall be effective as of the date of the certificate of authority.

Laws 1957, p. 306, § 2110.

§36-2111. Initial qualification, domestic mutuals.

When newly organized, a domestic mutual insurer may be authorized to transact any one or more kinds of insurance other than title insurance. When applying for an original certificate of authority as an insurer, a domestic mutual insurer must be otherwise qualified therefor under this code, must possess and maintain the minimum requirements for surplus in regard to policyholders as set forth in Sections 610 and 611 of this code, and must have received and accepted bona fide applications with respect to substantial insurable subjects for insurance coverage of a substantial character of the kind of insurance proposed to be transacted, must have collected in full and in cash the proper premium therefor at a rate substantially equal to that usually charged by stock insurers for comparable coverages, must have surplus funds on hand as at completion of issuance of all such policies so applied for, or, in lieu of such applications, premiums, and surplus, may deposit surplus, all in accordance with the requirements set forth in Sections 610 and 611 of this code.

Laws 1957, p. 306, § 2111; Laws 1980, c. 185, § 5, eff. Oct. 1, 1980.

§36-2112. Additional kinds of insurance, mutual.

A domestic mutual insurer after being authorized to transact one kind of insurance shall be authorized by the Insurance Commissioner to transact such additional kinds of insurance as are authorized under Section 609 of Article 6 and upon otherwise qualifying therefor and depositing and thereafter maintaining on deposit with the State Treasurer through the Insurance Commissioner unimpaired surplus funds in amount not less than the amount of capital required of a domestic stock insurer transacting like kinds of insurance, and subject further to the additional surplus requirements of Section 611 of Article 6 if applicable (expendable additional surplus in amount of one-half (1/2) of required surplus if it qualifies to transact more than one kind of insurance within first five (5) years).

Laws 1957, p. 307, § 2112.

§36-2113. Bylaws of mutual.

A. The initial board of directors of a domestic mutual insurer shall adopt original bylaws for the government of the corporation and conduct of its business. Such bylaws shall be subject to the approval of the insurer's members at the next succeeding annual meeting of members, and no bylaw provision shall thereafter be

effective which is not so approved. Bylaws shall be revoked or modified only by two-thirds (2/3) favorable vote of the insurer's members voting either in person or by proxy at a meeting of which notice was given as provided in the bylaws.

B. The bylaws shall provide that each member of the insurer is entitled to one vote in the election of corporate directors and on all matters coming before membership meetings, and that such vote may be exercised in person or by proxy.

C. The insurer shall promptly file with the Commissioner a copy, certified by the insurer's secretary, of such bylaws and of every modification thereof or of addition thereto. The Commissioner shall disapprove any bylaw provision deemed by him to be unlawful. The insurer shall not, after receiving written notice of such disapproval and during the existence thereof, effectuate any bylaw provision so disapproved; provided, however, such disapproval shall constitute an order from which an appeal will lie, and such appeal may be perfected in such manner as is provided by this Code.

Laws 1957, p. 307, § 2113.

§36-2114. Quorum, members of mutual.

A domestic mutual insurer may in its bylaws adopt a reasonable provision for determining a quorum of members at any meeting thereof, but no provisions recognizing a quorum of fewer than a simple majority of all the insurer's members present either in person or by proxy shall be effective unless approved as reasonable by the Insurance Commissioner. This section shall not affect any other provision of law requiring vote of a larger percentage of members for a specified purpose.

Laws 1957, p. 307, § 2114.

§36-2115. Membership in mutuals.

A. Each holder of one or more insurance policies or contracts issued by a domestic mutual insurer, other than a contract or reinsurance, is a member of the insurer with all the rights and obligations of such membership, and each such policy or contract so issued shall so specify.

B. Any person, government or governmental agency, state or political estate, trustee or fiduciary may be a member of a domestic, foreign or alien mutual insurer.

C. The insurer shall be entitled to charge and collect initial membership and/or policy fees, in addition to the premiums.

Laws 1957, p. 307, § 2115.

§36-2116. Corporate rights of mutual members.

With respect to the management, records, and affairs of the insurer, a member of a domestic mutual insurer shall have the same

character of rights and relationship as a stockholder has toward a domestic stock insurer.

Laws 1957, p. 308, § 2116.

§36-2119. Nonassessable policies, mutual insurers.

A. While it maintains on deposit with the State Treasurer through the Insurance Commissioner surplus funds in amount not less than the paid-in capital required of a domestic stock insurer transacting like kinds of insurance, a domestic mutual insurer may extinguish the contingent liability of its members as to all policies in force, and may omit provisions imposing contingent liability in all its policies currently issued.

B. When such surplus funds have been so deposited and the Commissioner has so ascertained, he shall issue to the insurer at its request his certificate authorizing such extinguishment and omission of contingent liability.

C. A foreign or alien mutual insurer may issue nonassessable policies to its members in this state in accordance with its charter and the laws of its domicile, provided the standards and requirements of the laws of the state of such domicile with respect to the issuance of nonassessable policies are substantially equivalent to or higher than the legal requirements in Oklahoma.
Laws 1957, p. 308, § 2119.

§36-2120. Nonassessable policies - revocation of authority.

A. The Insurance Commissioner shall revoke the authority of a domestic mutual insurer to issue policies if at any time the insurer's assets are less than the sum of its liabilities and the surplus required for such authority, or if the insurer, by resolution of its board of directors approved by a majority of its members, requests that the authority be revoked.

B. Policyholders, members or subscribers of a mutual insurer shall at no time be liable for assessment on policies by such insurer. Henceforth, no policies shall be issued or renewed by a domestic mutual insurer which contain provisions for assessment or contingent liability of an insured, member or subscriber.

Laws 1957, p. 308, § 2120; Laws 1981, c. 112, § 2.

§36-2121. Participating policies.

A. If so provided in its articles of incorporation, a domestic stock or domestic mutual insurer may issue any or all of its policies with or without participation in profits, savings, or unabsorbed portions of premiums, may classify policies issued on a participating or nonparticipating basis, and may determine the right to participate and the extent of participation of any class or classes of policies. Any such classification or determination shall be reasonable, and shall not unfairly discriminate as between

policyholders within the same such classification. A life insurer may issue both participating and nonparticipating policies only if the right or absence of right to participate is reasonably related to the premium charged.

B. No dividend, otherwise earned, shall be made contingent upon the payment of renewal premium on any policy.

Laws 1957, p. 309, § 2121.

§36-2122. Dividend to stockholders.

A. A domestic stock insurer shall not pay any ordinary cash dividend to stockholders except out of that part of its available surplus funds which is derived from realized net profits on its business. The restriction shall apply to all extraordinary dividends, as defined in subsection B of Section 1636 of this title.

B. A stock dividend may be paid out of any available surplus funds in excess of the aggregate amount of surplus loaned to the insurer pursuant to Section 2125 of this article.

C. A dividend otherwise proper may be payable out of the insurer's earned surplus even though its total surplus is then less than the aggregate of its past contributed surplus resulting from issuance of its capital stock at a price in excess of the par value thereof.

Added by Laws 1957, p. 309, § 2122. Amended by Laws 1988, c. 148, § 1, eff. Nov. 1, 1988; Laws 2000, c. 353, § 14, eff. Nov. 1, 2000; Laws 2024, c. 195, § 9, eff. Nov. 1, 2024.

§36-2123. Dividends to mutual policyholders.

A. The directors of a domestic mutual insurer may from time to time apportion and pay or credit to its members dividends only out of that part of its surplus which is in excess of its required minimum surplus.

B. A dividend otherwise proper may be payable out of such savings and earnings even though the insurer's total surplus is then less than the aggregate of its contributed surplus.

Laws 1957, p. 309, § 2123.

§36-2124. Illegal dividends - penalty.

A. Any director of a domestic stock or mutual insurer who votes for or concurs in declaration or payment of an illegal dividend to stockholders or members shall upon conviction thereof be guilty of a misdemeanor, and shall be jointly and severally liable, together with other such directors, for any loss thereby sustained by the insurer.

B. The stockholders or members receiving such an illegal dividend shall be liable in the amount thereof to the insurer.

C. The Insurance Commissioner may revoke or suspend the certificate of authority of an insurer which has declared or paid an illegal dividend.

Laws 1957, p. 309, § 2124.

§36-2125. Borrowed surplus.

A. A domestic stock or mutual insurer may borrow money to defray the expenses of its organization, provide it with surplus funds, or for any purpose required by its business, upon a written agreement that such money is required to be repaid only out of the insurer's surplus in excess of that stipulated in such agreement. The form of the agreement must be submitted for approval to the Commissioner to assure it is consistent with the requirements of this section. If such agreement is not approved or disapproved by the Commissioner within fifteen (15) days after the date of its filing, it shall be deemed approved. The agreement may provide for interest at the rate agreed upon, but not exceeding a rate of interest approved by the Insurance Commissioner, which interest shall or shall not constitute a liability of the insurer as to its funds other than such excess of surplus, as stipulated in the agreement. Repayment of such loan shall not be made unless it is approved in advance by the Commissioner. Such repayment shall be deemed approved unless within fifteen (15) days after the date of such filing the insurer is notified in writing of the Commissioner's disapproval and the reasons therefor.

B. Money so borrowed, together with the interest thereon if so stipulated in the agreement, shall not form a part of the insurer's legal liabilities except as to its surplus in excess of the amount thereof stipulated in the agreement, or be the basis of any setoff; but until repaid, financial statements filed or published by the insurer shall show as a footnote thereto the amount thereof then unpaid together with any interest thereon accrued but unpaid.

C. If a domestic mutual insurer, the insurer in advance of any such loan shall file with the Insurance Commissioner a statement of the purposes of the loan and a copy of the proposed loan agreement, which shall be subject to the approval of the Commissioner. The loan and agreement shall be deemed approved unless within fifteen (15) days after date of such filing the insurer is notified in writing of the Commissioner's disapproval and the reasons therefor. The Commissioner shall so disapprove any such proposed loan or agreement if he finds that the loan is reasonably unnecessary or excessive for the purpose intended, or that the terms of the loan agreement are not fair and equitable to the parties, and to other similar lenders, if any, to the insurer, or that the information so filed by the insurer is inadequate, specifying the respects in which it is so inadequate.

D. Any such loan to a mutual insurer or substantial portion thereof shall be repaid by the insurer out of earned surplus when no longer reasonably necessary for the purpose originally intended. No repayment of such a loan shall be made by a mutual insurer unless in advance approved by the Commissioner.

E. This section shall not apply to loans obtained by the insurer in ordinary course of business from banks and other financial institutions, nor to loans secured by pledge of assets. Amended by Laws 1983, c. 99, § 3, emerg. eff. May 9, 1983.

§36-2126. Prohibited interests of officers, directors in certain transactions.

A. No director or officer of an insurer, organized under the laws of this state, and no person who is directly or indirectly the beneficial owner of more than ten percent (10%) of any class of equity security of any such insurance company, shall receive, except as permitted by this section, any money or valuable thing, either directly or indirectly or through any substantial interest in any other corporation, firm or business unit for negotiating, procuring, recommending or aiding in any purchase, sale or exchange of property or loan, made by any such company or any subsidiary thereof; nor shall he be pecuniarily interested, either as principal, coprincipal, agent or beneficiary, either directly or indirectly, or through any substantial interest in any other corporation, firm or business unit, in any such purchase, sale, exchange or loan; nor shall such company make any loan to or guarantee the financial obligation of any such director, officer or shareholder, either directly or indirectly, or through its subsidiaries, nor shall any such director, officer or shareholder accept any such loan or guarantee either directly or indirectly.

B. 1. "Person", as used herein, shall mean an individual, a corporation, a partnership, an association, a joint-stock company, a business trust or an unincorporated organization; and

2. "Subsidiary", as used herein, shall mean any corporation in which an insurance company owns fifty percent (50%) or more of any class of equity securities of such corporation, or which is managed by or is directly or indirectly controlled by or is subject to control by an insurance company.

C. Nothing in this section shall be construed as prohibiting the following:

1. Any such director, officer or shareholder from becoming a policyholder of the insurance company and enjoying the usual rights of a policyholder or from participating as beneficiary in any pension plan, deferred compensation plan, profit-sharing or bonus plan, stock option plan, or similar plan adopted by the insurance company and to which he may be eligible under the terms of such plan; or prohibit any such director, officer or shareholder from

receiving salaries, bonuses and other remuneration for services rendered to the insurance company as an employee and not in violation of other provisions of the Insurance Code;

2. Professional services performed by such directors for duties not placed by law upon a director and director's fees and expense reimbursement for the performance of their duties as directors;

3. The approval and payment of lawful dividends to policyholders and shareholders;

4. Any other arms-length transaction not forbidden by other statutes between such directors, officers and shareholders and such insurance company provided such transactions are approved prior to the making thereof by the Commissioner;

5. Any transactions within an insurance holding company system by insurers with their holding companies, subsidiaries or affiliates that are not prohibited by law, that meet the test of being fair and proper, and that are regulated by other statutes; or

6. Any transactions or arrangements not prohibited by law that meet the test of being fair and proper.

Amended by Laws 1983, c. 99, § 4, emerg. eff. May 9, 1983; Laws 1987, c. 175, § 21, eff. Nov. 1, 1987.

§36-2126.1. Purchase and sale of equity interests in domestic stock insurers by officers.

A. Every person who is directly or indirectly the beneficial owner of more than ten percent (10%) of any class of equity security of a domestic stock insurer or who is a director or officer of such insurer shall file in the office of the Insurance Commissioner on or before the thirty-first day of October, nineteen hundred sixty-five or within ten (10) days after he becomes such beneficial owner, director or officer a statement, in such form and detail and subject to such rules and regulations as the Commissioner may prescribe, of the amount of all equity securities of such insurer of which he is the beneficial owner, and within ten (10) days after the close of each calendar month, thereafter, if there has been a change in such ownership during such month, shall file in the office of the Commissioner a statement, in such form and detail and subject to such rules and regulations as the Commissioner may prescribe, indicating his ownership at the close of the calendar month and such changes in his ownership as have occurred during such calendar month.

B. For the purpose of preventing the unfair use of information which may have been obtained by such beneficial owner, director or officer by reason of his relationship to such insurer, any profit realized by him from any purchase and sale, or any sale and purchase, of any equity security of such insurer within any period of less than six (6) months, unless such equity security was acquired in good faith in connection with a debt previously

contracted, shall inure to and be recoverable by the insurer, irrespective of any intention on the part of such beneficial owner, director or officer in entering into such transaction of holding the equity security purchased or of not repurchasing the stock sold for a period exceeding six (6) months. Suit to recover such profit may be instituted at law or in equity in any court of competent jurisdiction by the insurer or by the owner of any equity security of the insurer in the name and in behalf of the insurer if the insurer shall fail or refuse to bring such suit within sixty (60) days after request or shall fail diligently to prosecute the same thereafter; but no such suit shall be brought more than two (2) years after the date such profit was realized. This paragraph shall not be construed to cover any transaction where such beneficial owner was not such both at the time of the purchase and sale, or the sale and purchase, of the security involved, or any transaction or transactions which the Commissioner may by rules and regulations exempt as not comprehended within the purpose of this paragraph.

C. It shall be unlawful for any such beneficial owner, director or officer, directly or indirectly, to sell any equity security of such insurer if the person selling the stock or his principal (i) does not own the security sold, or (ii) if owning the security, does not deliver it against such sale within twenty (20) days thereafter, or does not within five (5) days after such sale deposit it in the mails or other usual channels of transportation; but no person shall be deemed to have violated this paragraph if he proves that notwithstanding the exercise of good faith he was unable to make such delivery or deposit within such time, or that to do so would cause undue inconvenience or expense.

D. The provisions of paragraph B of this section shall not apply to any purchase and sale, or sale and purchase, and the provisions of paragraph C of this section shall not apply to any sale, of an equity security of a domestic stock insurance company not then or theretofore held by him in an investment account, by a dealer in the ordinary course of his business and incident to the establishment or maintenance by him of a primary or secondary market (otherwise than on an exchange as defined in the Securities Exchange Act of 1934) for such security. The Commissioner may, by such rules and regulations as he deems necessary or appropriate in the public interest, define and prescribe terms and conditions with respect to securities held in an investment account and transactions made in the ordinary course of business and incident to the establishment or maintenance of a primary or secondary market.

E. The provisions of paragraphs A, B and C of this section shall not apply to foreign or domestic arbitrage transactions unless made in contravention of such rules and regulations as the Commissioner may adopt in order to carry out the purpose of this act.

F. The term "equity security" when used in this act means any stock or similar security; or any security convertible, with or without consideration, into such a security, or carrying any warrant or right to subscribe to or purchase such a security; or any such warrant or right; or any other security which the Commissioner shall deem to be of similar nature and consider necessary or appropriate, by such rules and regulations as he may prescribe in the public interest or for the protection of investors, to treat as an equity security. The term "officer" when used in this act means a director, president, vice-president, treasurer, actuary, secretary, controller, and any other person who performs for the company functions corresponding to those performed by the foregoing officers. The term "Commissioner" when used in this act means the Insurance Commissioner. The term "insurer" when used in this act means any domestic stock insurer. The term "person" when used in this act includes any firm, partnership, association or corporation.

G. The Commissioner shall have the power to make such rules and regulations as may be necessary for the execution of the functions vested in him by paragraphs A through F of this section, and may for such purpose classify domestic stock insurance companies, securities, and other persons or matters within his jurisdiction. No provision of paragraphs A, B and C of this section, imposing any liability shall apply to any act done or omitted in good faith in conformity with any rule or regulation of the Commissioner, notwithstanding that such rule or regulation may, after such act or omission, be amended or rescinded or determined by judicial or other authority to be invalid for any reason.

H. For the purpose of carrying into effect the provisions of this act, there is hereby imposed a filing fee of Two Dollars (\$2.00) on each monthly statement filed pursuant to this act. Such fee shall be due and payable when such statement is filed and shall be paid to the Insurance Commissioner.

Added by Laws 1965, c. 439, § 1, operative Oct. 1, 1965. Amended by Laws 1979, c. 30, § 11, emerg. eff. April 6, 1979; Laws 1984, c. 215, § 6, operative June 30, 1984; Laws 2009, c. 432, § 17, eff. July 1, 2009.

§36-2126.4. Proxies, consents and authorizations of domestic stock insurers.

A. Application of Act. This act is applicable to all domestic stock insurers having ten or more stockholders and to all persons who shall solicit, or permit the use of his name to solicit, by mail or otherwise, any proxy, consent or authorization in respect of any stock of such insurer.

B. Proxies, consents and authorizations.

No domestic stock insurer, or any director, officer or employee of such insurer subject to Paragraph A hereof, or any other person

shall solicit, or permit the use of his name to solicit, by mail or otherwise, any proxy, consent or authorization in respect of any stock of such insurer in contravention of this act or in contravention of rules and regulations prescribed by the Insurance Commissioner.

C. Disclosure of equivalent information.

Unless proxies, consents or authorizations in respect of a stock of a domestic insurer subject to Paragraph A hereof are solicited by or on behalf of the management of such insurer from the holders of record of stock of such insurer in accordance with this act prior to an annual or other meeting, such insurer shall, in accordance with this act and/or such further regulations as the Commissioner may adopt, file with the Commissioner and transmit to all stockholders of record information substantially equivalent to the information which would be required to be transmitted if a solicitation were made.

D. Definitions.

1. The definitions and instructions set out in Schedule SIS, as promulgated by the National Association of Insurance Commissioners, to the extent that they are not in conflict with this act, shall be applicable for purposes of this act.

2. The terms "solicit" and "solicitation" for purposes of this act shall include:

(a) any request for a proxy, whether or not accompanied by or included in a form of proxy; or

(b) any request to execute or not to execute, or to revoke, a proxy; or

(c) the furnishing of a proxy or other communication to stockholders under circumstances reasonably calculated to result in the procurement, withholding or revocation of a proxy.

3. The terms "solicit" or "solicitation" shall not include:

(a) any solicitation by a person in respect of stock of which he is the beneficial owner; (b) action by a broker or other person in respect to stock carried in his name or in the name of his nominee in forwarding to the beneficial owner of such stock soliciting material received from the company, or impartially instructing such beneficial owner to forward a proxy to the person, if any, to whom the beneficial owner desires to give a proxy, or impartially requesting instructions from the beneficial owner with respect to the authority to be conferred by the proxy and stating that a proxy will be given if the instructions are received by a certain date.

(c) the furnishing of a form of proxy to a stockholder upon the unsolicited request of such stockholder, or the performance by any person of ministerial acts on behalf of a person soliciting a proxy.

E. Information to be furnished to stockholders.

1. No solicitation subject to this act shall be made unless each solicited is concurrently furnished or has previously been furnished with a written proxy statement which meets the requirements and contains information specified and described in Items 1 to 16 inclusive, as set forth in subparagraph (a) of this subparagraph 1 and which are hereinafter referred to as Schedule A.

(a) Schedule A. Information required in a proxy statement is as follows:

Item 1. Revocability of proxy.

State whether or not the person giving the proxy has the power to revoke it. If the right of revocation before the proxy is exercised is limited or is subject to compliance with any formal procedure, such limitation or procedure must be described.

Item 2. Dissenters' right of appraisal.

Outline briefly the rights of appraisal or similar rights of dissenting stockholders with respect to any matter to be acted upon and indicate any statutory procedure required to be followed by such stockholders in order to perfect their rights. Where such rights may be exercised only within a limited time after the date of the adoption of a proposal, the filing of a charter amendment, or other similar act, the proposal must state whether the person solicited will be notified of such date.

Item 3. Persons making solicitations not subject to Paragraph K.

(1) If the solicitation is made by the management of the insurer, it must be so stated. The name of any director of the insurer who has informed the management in writing that he intends to oppose any action intended to be taken by the management and the action which he intends to oppose must be stated.

(2) If the solicitation is made otherwise than by the management of the insurer, the names and addresses of the persons by whom and on whose behalf it is made and the names and addresses of the persons by whom the cost of solicitation has been or will be borne, directly or indirectly, must be stated.

(3) If the solicitation is to be made by specially engaged employees or paid solicitors, (i) the material features of any contract or arrangement for such solicitation, (ii) the identity of the parties, and (iii) the cost or anticipated cost thereof must be stated.

Item. 4. Interest of certain persons in matters to be acted upon.

Describe briefly any substantial interest, direct or indirect, by stockholdings or otherwise, of any director, nominee for election for director, officer and, if the solicitation is made otherwise than on behalf of management, each person on whose behalf the

solicitation is made, in any matter to be acted upon other than elections to office.

Item. 5. Stocks and principal stockholders.

(1) State, as to each class of voting stock of the insurer entitled to be voted at the meeting, the number of shares outstanding and the number of votes to which each class is entitled.

(2) Give the date as of which the record list of stockholders entitled to vote at the meeting will be determined. If the right to vote is not limited to stockholders of record on that date, the conditions under which other stockholders may be entitled to vote shall be indicated.

Item 6. Nominees and directors.

If action is to be taken with respect to the election of directors furnish the following information, in tabular form to the extent practicable, with respect to each person nominated for election as a director and each other person whose term of office as a director will continue after the meeting: (a) Name each such person, state when his term of office or the term of office for which he is a nominee will expire, and all other positions and offices with the insurer presently held by him and indicate which persons are nominees for election as directors at the meeting.

(b) State his present principal occupation or employment and give the name and principal business of any corporation or other organization in which such employment is carried on. Furnish similar information as to all of his principal occupations or employments during the last five years, unless he is now a director and was elected to his present term of office by a vote of stockholders at a meeting for which proxies were solicited under this act.

(c) If he is or has previously been a director of the insurer, state the period or periods during which he has served as such.

(d) State, as of the most recent practicable date, the most recent practicable date, the approximate amount of each class of stock of the insurer or any of its parents, subsidiaries or affiliates other than directors' qualifying shares, beneficially owned directly or indirectly by him. If he is not the beneficial owner of any such stocks make a statement to that effect.

Item 7. Remuneration and other transactions with management and others.

Furnish the information reported or required in item one of Schedule SIS under the heading "Information Regarding Management and Directors" if action is to be taken with respect to (a) the election of directors, (b) any remuneration plan, contract or arrangement in which any director, nominee for election as a director, or officer of the insurer will participate, (c) any pension or retirement plan in which any such person will participate, or (d) the granting of extension to any such person of any options, warrants or rights to

purchase any stocks, other than warrants or rights issued to stockholders, as such, on a pro rata basis. If the solicitation is made on behalf of persons other than the management information shall be furnished only as to Item IA of the aforesaid heading of Schedule SIS.

Item 8. Bonus, profit sharing and other remuneration plans.

If action is to be taken with respect to any bonus, profit sharing, or other remuneration plan, of the insurer, furnish the following information: (a) A brief description of the material features of the plan, each class of persons who will participate therein, the approximate number of persons in each such class, and the basis of such participation.

(b) The amounts which would have been distributable under the plan during the last calendar year to (1) each person named in item seven of this schedule, (2) directors and officers as a group, and (3) to all other employees as a group, if the plan had been in effect.

(c) If the plan to be acted upon may be amended (other than by a vote of stockholders) in a manner which would materially increase the cost thereof to the insurer or to materially alter the allocation of the benefits as between the groups specified in paragraph (b), of this item the nature of such amendments must be specified.

Item 9. Pension and retirement plans.

If action is to be taken with respect to any pension or retirement plan of the insurer, furnish the following information:

(a) A brief description of the material features of the plan, each class of persons who will participate therein, the approximate number of persons in each such class, and the basis of such participation.

(b) State (1) the approximate total amount necessary to fund the plan with respect to past services, the period over which such amount is to be paid, and the estimated annual payments necessary to pay the total amount over such period; (2) the estimated annual payment to be made with respect to current services; and (3) the amount of such annual payments to be made for the benefit of (i) each person named in Item seven of this schedule, (ii) directors and officers as a group, and (iii) employees as a group.

(c) If the plan to be acted upon may be amended (other than by a vote of stockholders) in a manner which would materially increase the cost thereof to the insurer or to materially alter the allocation of the benefits as between the groups specified in subparagraph (b) (3) of this item, the nature of such amendments should be specified.

Item 10. Options, warrants, or rights.

If action is to be taken with respect to the granting or extension of any options, warrants or rights (all referred to herein as "warrants") to purchase stock of the insurer or any subsidiary or affiliate, other than warrants issued to all stockholders on a pro rata basis, information must be furnished as follows: (a) The title and amount of stock called for or to be called for, the prices, expiration dates and other material conditions upon which the warrants may be exercised, the consideration received or to be received by the insurer, subsidiary or affiliate for the granting or extension of the warrants and the market value of the stock called for or to be called for by the warrants, as of the latest practicable date.

(b) If known, state separately the amount of stock called for or to be called for by warrants received or to be received by the following persons, naming each such person: (1) each person named in Item seven of this schedule, and (2) each other person who will be entitled to acquire five percent (5%) or more of the stock called for or to be called for by such warrants.

(c) If known, state also the total amount of stock called for or to be called for by such warrants, received or to be received by all directors and officers of the company as a group and all employees, without naming them.

Item 11. Authorization or issuance of stock.

1. If action is to be taken with respect to the authorization or issuance of any stock of the insurer, the title, amount and description of the stock to be authorized or issued must be furnished.

2. If the shares of stock are other than additional shares or common stock of a class outstanding, furnish a brief summary of the following, if applicable: dividend, voting, liquidation, preemptive, and conversion rights, redemption and sinking fund provision, interest rate and date of maturity.

3. If the shares of stock to be authorized or issued are other than additional shares of common stock of a class outstanding, the Commissioner may require financial statements comparable to those contained in the annual report.

Item 12. Mergers, consolidations, acquisitions and similar matters.

1. If the action is to be taken with respect to a merger, consolidation, acquisition, or similar matter, furnish in brief outline the following information:

(a) The rights of appraisal or similar rights of dissenters with respect to any matters to be acted upon. Indicate any procedure required to be followed by dissenting stockholders in order to perfect such rights.

(b) The material features of the plan or agreement.

(c) The business done by the company to be acquired or whose assets are being acquired.

(d) If available, the high and low sales prices for each quarterly period within two years.

(e) The percentage of outstanding shares which must approve the transaction before it is consummated.

2. For each company involved in a merger, consolidation or acquisition, the following financial statements should be furnished:

(a) A comparative balance sheet as of the close of the last two fiscal years.

(b) A comparative statement of operating income and expenses for each of the last two fiscal years and, as a continuation of each statement, a statement of earning per share after related taxes and cash dividends paid per share.

(c) A pro forma combined balance sheet and income and expenses statement for the last fiscal year giving effect to the necessary adjustments with respect to the resulting company.

Item 13. Restatement of accounts.

If action is to be taken with respect to the restatement of any asset, capital, or surplus of the insurer, furnish the following information:

(a) State the nature of the restatement and the date as of which it is to be effective.

(b) Outline briefly the reasons for the restatement and for the selection of the particular effective date.

(c) State the name and amount of each account affected by the restatement and the effect of the restatement thereon.

Item. 14. Matters not required to be submitted.

If action is to be taken with respect to any matter which is not required to be submitted to a vote of stockholders, state the nature of such matter, the reason for submitting it to a vote of stockholders and what action is intended to be taken by the management in the event of a negative vote on the matter by the stockholders.

Item 15. Amendment of charter, bylaws, or other documents.

If action is to be taken with respect to any amendment of the insurer's charter, bylaws or other documents as to which information is not required above, state briefly the reasons for and general effect of such amendment and the vote needed for its approval.

Item 16. Additional information.

1. Additional information in such form and detail as the Commissioner may prescribe or request shall be furnished and included.

2. If the solicitation is made on behalf of the management of the insurer and relates to an annual meeting of stockholders at which directors are to be elected, each proxy statement furnished pursuant to subsection one hereof shall be accompanied or preceded

by an annual report (in preliminary or final form) to such stockholders containing such financial statements for the last fiscal year as are referred to in Schedule SIS under the heading "Financial Reporting to Stockholders." Subject to the foregoing requirements with respect to financial statements, the annual report to stockholders may be in any form deemed suitable by the management and approved by the Commissioner.

3. Two copies of each report sent to the stockholders pursuant to this section shall be mailed to the Commissioner not later than the date on which such report is first sent or given to stockholders or the date on which preliminary copies of solicitation material are filed with the Commissioner pursuant to subparagraph 1 of Paragraph G, whichever date is later.

F. Requirements as to proxy.

1. The form of proxy (a) shall indicate in boldface type whether or not the proxy is solicited on behalf of the management (b) shall provide a specially designated blank space for dating the proxy and (c) shall identify clearly and impartially each matter or group of related matters intended to be acted upon, whether proposed by the management, or stockholders. No reference need be made to proposals as to which discretionary authority is conferred pursuant to subparagraph 3 of this Paragraph F.

2. Means shall be provided in the proxy for the person solicited to specify by ballot a choice between approval or disapproval of each matter or group of related matters referred to therein, other than elections to office. A proxy may confer discretionary authority with respect to matters as to which a choice is not so specified if the form of proxy states in boldface type how it is intended to vote the shares or authorization represented by the proxy in each such case.

3. A proxy may confer discretionary authority with respect to other matters which may come before the meeting, provided the persons on whose behalf the solicitation is made are not aware a reasonable time prior to the time the solicitation is made that any other matters are to be presented for action at the meeting and provided further that a specific statement to that effect is made in the proxy statement or in the form of proxy. A proxy may also confer discretionary authority with respect to any proposal omitted from the proxy statement and form of proxy pursuant to Paragraph H.

4. No proxy shall confer authority (a) to vote for the election of any person to any office for which a bona fide nominee is not named in the proxy statement, or (b) to vote at any annual meeting other than the next annual meeting (or any adjournment thereof) to be held after the date on which the proxy statement and form of proxy are first sent or given to stockholders.

5. The proxy statement or form of proxy shall provide, subject to reasonable specified conditions, that the proxy will be voted and

that where the person solicited specifies by means of ballot provided pursuant to subparagraph 2 of this Paragraph F a choice with respect to any matter to be acted upon, the vote will be in accordance with the specifications so made.

6. The information included in the proxy statement shall be clearly presented and the statements made shall be divided into groups according to subject matter, with appropriate headings. All printed proxy statements shall be clearly and legibly presented.

G. Material required to be filed.

1. Two preliminary copies of the proxy statement and form of proxy and any other soliciting material to be furnished to stockholders concurrently therewith shall be filed with the Commissioner at least ten days prior to the date definitive copies of such material are first sent or given to stockholders, or such shorter period prior to that date as the Commissioner may authorize upon a written showing of good cause therefor.

2. Two preliminary copies of any additional soliciting material relating to the same meeting or subject matter to be furnished to stockholders subsequent to the proxy statements shall be filed with the Commissioner at least two days (exclusive of Saturdays, Sundays or holidays) prior to the date copies of this material are first sent or given to stockholders or a shorter period prior to such date as the Commissioner may authorize upon a written showing of good cause therefor.

3. Two definitive copies of the proxy statement, form of proxy and all other soliciting material, in the form in which this material is furnished to stockholders, shall be filed with, or mailed for filing to, the Commissioner not later than the date such material is first sent or given to the stockholders.

4. Where any proxy statement, form of proxy or other material filed pursuant to this act is amended or revised, two of the copies shall be marked to clearly show such changes.

5. Copies of replies to inquiries from stockholders requesting further information and copies of communications which do no more than request that forms of proxy theretofore solicited be signed and returned need not be filed pursuant to this section.

6. Notwithstanding the provisions of subparagraphs 1 and 2 hereof and of subparagraph 5 of Paragraph K, copies of soliciting material in the form of speeches, press releases and radio or television scripts may, but need not, be filed with the Commissioner prior to use or publication. Definitive copies, however, shall be filed with or mailed for filing to the Commissioner as required by subparagraph 3 of this Paragraph G not later than the date such material is used or published. The provisions of subparagraphs 1 and 2 of this Paragraph G and subparagraph 5 of Paragraph K shall apply, however, to any reprints or reproductions of all or any part of such material.

H. Proposals of stockholders.

Proposals of stockholders shall be presented in such form and detail as may be approved by the Commissioner.

I. False or misleading statements.

No solicitation subject to this act shall be made by means of any proxy statement, form of proxy, notice of meeting, or other communication, written or oral, containing any statement which at the time and in the light of the circumstances under which it is made, is false or misleading with respect to any material fact, or which omits to state any material fact necessary in order to make the statements therein not false or misleading or necessary to correct any statement in any earlier communication with respect to the solicitation of a proxy for the same meeting or subject matter which has become false or misleading.

J. Prohibition of certain solicitations.

No person making a solicitation which is subject to this act shall solicit any undated or postdated proxy or any proxy which provides that it shall be deemed to be dated as of any date subsequent to the date on which it is signed by the stockholder.

K. Special provisions applicable to election contests.

1. Applicability.

This Paragraph shall apply to any solicitation subject to this act by any person or group for the purpose of opposing a solicitation subject to this act by any other person or group with respect to the election or removal of directors at any annual or special meeting of stockholders.

2. Participant or participant in a solicitation.

(a) For purposes of this Paragraph the term "participant" and "participant in a solicitation" include: (i) the insurer; (ii) any director of the insurer, and any nominee for whose election as a director proxies are solicited; (iii) any other person, acting alone or with one or more persons, committees or groups, in organizing, directing or financing the solicitation.

(b) For the purposes of this Paragraph K the terms "participant" and "participant in a solicitation" do not include: (i) a bank, broker or dealer who, in the ordinary course of business, lends money or executes orders for the purchase or sale of stock and who is not otherwise a participant; (ii) any person or organization retained or employed by a participant to solicit stockholders or any person who merely transmits proxy soliciting material or performs ministerial or clerical duties; (iii) any person employed in the capacity of attorney, accountant, or advertising, public relations or financial adviser, and whose activities are limited to the performance of his duties in the course of such employment; (iv) any person regularly employed as an officer or employee of the insurer or any of its subsidiaries or affiliates who is not otherwise a participant; or (v) any officer or

director of, or any person regularly employed by any other participant, if such officer, director, or employee is not otherwise a participant.

3. Filing of required information.

(a) No solicitation subject to this section shall be made by any person other than the management of an insurer unless at least five business days prior thereto, or such shorter period as the Commissioner may authorize upon a written showing of good cause therefor, there has been filed with the Commissioner, by or on behalf of each participant in such solicitation, a statement in duplicate containing the information specified and described in Items 1 to 6 inclusive, as set forth in subparagraph (g) of this subparagraph 3 and which are hereinafter referred to as Schedule B. A copy of any material proposed to be distributed to stockholders in furtherance of such solicitation also shall be filed as in this subparagraph provided. Where preliminary copies of any materials are filed, distribution to stockholders should be deferred until the Commissioner's comments mailed within fourteen working days after the filing have been received and complied with.

(b) Within five business days after a solicitation subject to this Paragraph K is made by the management of an insurer, or such longer period as the Commissioner may authorize upon a written showing of good cause therefor, there shall be filed with the Commissioner by or on behalf of each participant in such solicitation, other than the insurer, and by or on behalf of each management nominee for director, a statement in duplicate containing the information specified by Schedule B.

(c) If any solicitation on behalf of management or any other person has been made, or if proxy material is ready for distribution, prior to a solicitation subject to this section in opposition thereto, a statement in duplicate containing the information specified in Schedule B shall be filed with the Commissioner, by or on behalf of each participant in such prior solicitation, other than the insurer, as soon as reasonably practicable after the commencement of the solicitation in opposition thereto.

(d) If, subsequent to the filing of the statements required by paragraphs (a), (b) and (c) of this subparagraph 3, additional persons become participants in a solicitation subject to this rule, there shall be filed with the Commissioner, by or on behalf of each such person, a statement in duplicate containing the information specified by Schedule B, within three business days after such person becomes a participant, or such longer period as the Commissioner may authorize upon a written showing of good cause therefor.

(e) If any material change occurs in the facts reported in any statement filed by or on behalf of any participant, an appropriate

amendment to such statement shall be filed promptly with the Commissioner.

(f) Each statement and amendment thereto filed pursuant to this paragraph shall be part of the public files of the Commissioner.

(g) Schedule B. Information to be included in statements filed by or on behalf of a participant (other than the insurer) in a proxy solicitation in an election contest is as follows:

Item 1. Insurer.

State the name and address of the insurer.

Item 2. Identity and background.

(a) State the following:

(1) Your name and business address. (2) Your present principal occupation or employment and the name, principal business and address of any corporation or other organization in which such employment is carried on.

(b) State the following: (1) Your residence address.

(2) Information as to all material occupations, positions, offices or employments during the last ten years, giving starting and ending dates of each and the name, principal business and address of any business corporation or other business organization in which each such occupation, position, office or employment was carried on.

(c) State whether or not you are or have been a participant in any other proxy contest involving this company or other companies within the past ten years. If so, identify the principals, the subject matter and your relationship to the parties and the outcome.

(d) State whether or not, during the past ten years, you have been convicted in a criminal proceeding (excluding traffic violations or similar misdemeanors) and, if so, give dates, nature of conviction, name and location of court, and penalty imposed or other disposition of the case. A negative answer to this subitem need not be included in the proxy statement or other proxy soliciting material.

Item 3. Interest in stock of the insurer.

(a) State the amount of each class of stock of the insurer which you own beneficially, directly or indirectly.

(b) State the amount of each class of stock of the insurer which you own of record but not beneficially.

(c) State with respect to the stock specified in (a) and (b) the amounts acquired within the past two years, the dates of acquisition and the amounts acquired on each date.

(d) If any part of the purchase price or market value of any of the stock specified in paragraph (c) is represented by funds borrowed or otherwise obtained for the purpose of acquiring or holding such stock, so state and indicate the amount of the indebtedness as of the latest practicable date. If such funds were borrowed or obtained otherwise than pursuant to a margin account or bank loan in the regular course of business of a bank, broker or

dealer, briefly describe the transaction, and state the names of the parties.

(e) State whether or not you are a party to any contracts, arrangements or understandings with any person with respect to any stock of the insurer, including but not limited to joint ventures, loan or option arrangements, puts or calls, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. If so name the persons with whom such contracts, arrangements, or understanding exist and give the details thereof.

(f) State the amount of stock of the insurer owned beneficially, directly or indirectly, by each of your associates and the names and address of each such associate.

(g) State the amount of each class of stock of any parent, subsidiary or affiliate of the insurer which you own beneficially, directly or indirectly.

Item 4. Further matters.

(a) Describe the time and circumstances under which you became a participant in the solicitation and state the nature and extent of your activities or proposed activities as a participant.

(b) Describe briefly, and where practicable state the approximate amount of, any material interest, direct or indirect, of yourself and of each of your associates in any material transactions since the beginning of the company's last fiscal year, or in any material proposed transactions, to which the company or any of its subsidiaries or affiliates was or is to be a party.

(c) State whether or not you or any of your associates have any arrangement or understanding with any person;

(1) With respect to any future employment by the insurer or its subsidiaries or affiliates; or

(2) With respect to any future transactions to which the insurer or any of its subsidiaries or affiliates will or may be a party.

If so, describe such arrangement or understanding and state the names of the parties thereto.

Item 5. Additional information.

Additional information in such form and detail as the Commissioner may prescribe or request shall be furnished and included.

Item 6. Signature.

The statement shall be dated and signed in the following manner:

I certify that the statements made in this statement are true, complete, and correct, to the best of my knowledge and belief.

(Date)

(Signature of
participant or

authorized
representative)

4. Solicitations prior to furnishing required written proxy statement.

Notwithstanding the provisions of subparagraph 1 of Paragraph 5, a solicitation subject to this section may be made prior to furnishing stockholders a written proxy statement containing the information specified in Schedule A with respect to such solicitation, provided that:

(a) The statements required by subparagraph 3 of this Paragraph K are filed by or on behalf of each participant in such solicitation.

(b) No form of proxy is furnished to stockholders prior to the time the written proxy statement required by subsection one of section five is furnished to such persons; provided, however, that this paragraph (b) shall not apply where a proxy statement then meeting the requirements of Schedule A has been furnished to stockholders.

(c) At least the information specified in paragraphs (b) and (c) of the statements required by subparagraph 3 of this Paragraph K to be filed by each participant, or an appropriate summary thereof, are included in each communication sent or given to stockholders in connection with the solicitation.

(d) A written proxy statement containing the information specified in Schedule A with respect to a solicitation is sent or given stockholders at the earliest practicable date.

5. Solicitations prior to furnishing required written proxy statement - Filing requirements.

Two copies of any soliciting material proposed to be sent or given to stockholders prior to the furnishing of the written proxy statement required by subparagraph 1 of Paragraph E shall be filed with the Commissioner in preliminary form at least five business days prior to the date definitive copies of such material are first sent or given to such persons, or shorter period as the Commissioner may authorize upon a written showing of good cause therefor.

6. Application of Paragraph K to report.

Notwithstanding the provisions of subparagraphs 2 and 3 of Paragraph E, two copies of any portion of the report referred to in subparagraph 2 of Paragraph E which comments upon or refers to any solicitation subject to this Paragraph, or to any participant in any such solicitation, other than the solicitation by the management, shall be filed with the Commissioner as proxy material subject to this regulation. Such portion of the report shall be filed with the Commissioner in preliminary form at least five business days prior to the date copies of the report are first sent or given to stockholders.

L. Fee imposed on insurers - Purpose - Dedication

For the purpose of carrying into effect the provisions of this Act, there is hereby levied upon each insurer subject to this Act, an annual fee of One Hundred Dollars (\$100.00). Such fee shall be due and payable on October 1, 1965, and on July 15 of each succeeding year and shall be paid to the Insurance Commissioner. All moneys collected by the Commissioner from the fees herein provided for, shall be deposited with the State Treasurer, who shall place the same to the credit of the Insurance Commissioner, in a depository fund to be known as the "Solicitations and Trading Regulatory Fund", under and subject exclusively to the control of the Commissioner for the purpose of fulfilling and accomplishing the conditions and purposes of this Act. The Commissioner shall employ and fix the salaries of such employees as are necessary to carry out the purpose of this Act and the administration thereof. All necessary salaries, and expenses incurred by the Commissioner in the performance of the duties placed upon him under this Act shall be a proper charge against, and shall be paid from such fund upon proper vouchers approved by the Commissioner. At the close of each fiscal year hereafter the Commissioner shall file with the State Auditor and Inspector a true and correct report of all fees collected by him during the previous fiscal year. All of said fees are hereby dedicated, appropriated and pledged to the accomplishment and fulfillment of the purposes of this Act, provided however, any of said moneys not so expended at the end of each fiscal year shall revert to the general revenue fund of this State.

M. Commissioner empowered to make rules.

The Insurance Commissioner is hereby authorized and empowered to promulgate such reasonable rules and regulations as are necessary to implement the purposes of this Act.

N. Definition of terms.

The term "insurer" when used in this Act means any domestic stock insurer. The term "Commissioner" when used in this Act means the Insurance Commissioner of the State of Oklahoma created by this Act. The term "person" when used in this Act includes any firm, partnership, association or corporation.

Laws 1965, c. 463, § 1, operative Oct. 1, 1965; Laws 1979, c. 30, § 12, emerg. eff. April 6, 1979.

§36-2127. Management and exclusive agency contracts.

A. No domestic stock or mutual insurer shall make any contract whereby any person or persons is granted or is to enjoy in fact the management of the insurer, or to have the controlling or preemptive right to produce substantially all insurance business for the insurer for an amount which will equal or exceed five percent (5%) of the insurer's net written premium, unless such contract is filed with the Commissioner and be subject to his approval. The contract shall be deemed approved unless disapproved by the Commissioner

within twenty (20) days after date of filing, subject to such reasonable extension of time as the Commissioner may require by notice given within such twenty (20) days. Any disapproval shall be delivered to the insurer in writing, stating the grounds therefor.

B. The Commissioner shall disapprove any such contract if he finds that it:

1. Subjects the insurer to excessive charges; or
2. Is to extend for an unreasonable length of time; or
3. Does not contain fair and adequate standards of performance;

or

4. Contains other inequitable provisions or provisions which impair the proper interests of stockholders or members of the insurer.

Amended by Laws 1983, c. 99, § 5, emerg. eff. May 9, 1983; Laws 1986, c. 251, § 36, eff. Nov. 1, 1986.

§36-2128. Impairment of capital or assets.

A. If the capital stock or expendable surplus of a domestic stock insurer is impaired to an extent of less than twenty percent (20%) of the required capital stock or expendable surplus, or the net surplus of a domestic mutual insurer is impaired to an extent of less than twenty percent (20%) of the minimum amount of surplus required of it by this Code for authority to transact the kinds of insurance being transacted, the Commissioner shall serve notice upon the insurer to make good the deficiency within sixty (60) days after service of such notice.

B. The deficiency may be made good in cash or in assets eligible under this code for the investment of the insurer's funds; or if a stock insurer by reduction of the insurer's capital to an amount not below the minimum required for the kinds of insurance thereafter to be transacted; or if a mutual insurer, by amendment of its certificate of authority to cover only such kind or kinds of insurance for which the insurer has on deposit sufficient surplus.

C. If the deficiency is not made good and proof thereof filed with the Commissioner within such sixty-day period, the insurer shall be deemed insolvent and the Commissioner may institute delinquency proceedings against it as authorized by this code. If such deficiency exists because of increased loss reserves required by the Insurance Commissioner, or because of disallowance by the Commissioner of certain assets or reduction of the value at which carried in the insurer's accounts, the Commissioner may in his discretion and upon application and good cause shown, extend for not more than an additional sixty (60) days the period within which such deficiency may be so made good and such proof thereof so filed.

D. If the Commissioner finds that the capital stock or expendable surplus of a domestic stock insurer is impaired to an extent of more than twenty percent (20%) of the required capital

stock or expendable surplus, or that the net surplus of a domestic mutual insurer is impaired to an extent of more than twenty percent (20%) of the minimum amount of surplus required of it by this code for authority to transact the kinds of insurance being transacted, the insurer shall be deemed insolvent and the Commissioner shall forthwith institute delinquency proceedings.
Laws 1957, p. 311, § 2128.

§36-2129. Mutualization of stock insurer.

A. A domestic stock insurer other than a life or title insurer may become a domestic mutual insurer pursuant to such plan and procedure as may be approved in advance by the Insurance Commissioner.

B. The Commissioner shall not approve any such plan, procedure, or mutualization unless:

1. It is equitable to both stockholders and policyholders;
2. It is subject to approval by a vote of the holders of not less than three-fourths (3/4) of the insurer's capital stock having voting rights and by a vote of not less than two-thirds (2/3) of the insurer's policyholders who vote on such plan in person, by proxy or by mail pursuant to such notice and procedure as may be approved by the Commissioner;
3. Mutualization will result in retirement of shares of the insurer's capital stock at a price not in excess of the fair market value thereof as determined by competent disinterested appraisers;
4. The plan provides for the purchase of the shares of any nonconsenting stockholder in accordance with the provisions of the Oklahoma General Corporation Act, and such nonconsenting stockholders shall have all the rights and restrictions applicable under said act to stockholders of a private corporation who do not consent to the agreed manner of converting the shares of stock of such private corporation upon proposal for consolidation;
5. The plan provides for definite conditions to be fulfilled by a designated early date upon which such mutualization will be deemed effective; and
6. The mutualization leaves the insurer with surplus funds reasonably adequate for the security of its policyholders and to continue successfully in business in the states in which it is then authorized to transact insurance, and for the kinds of insurance included in its certificate of authority.

C. This section shall not apply to mutualization under order of court pursuant to rehabilitation or reorganization of an insurer under Article 18, (Rehabilitation and Liquidation).
Amended by Laws 1986, c. 292, § 159, eff. Nov. 1, 1986.

§36-2130. Converting mutual insurer.

A. A domestic mutual insurer may become a domestic stock insurer pursuant to such plan and procedure as is approved in advance by the Insurance Commissioner.

B. The Commissioner shall not approve any such plan or procedure unless:

1. Equitable to the insurer's members;

2. Subject to approval by vote of not less than three-fourths (3/4) of the insurer's current members voting thereon in person, by proxy, or by mail at a meeting of members called for the purpose pursuant to such notice and procedure as may be approved by the Commissioner;

3. The equity of each policyholder in the insurer is determinable under a fair formula approved by the Commissioner, which such equity shall be based upon not less than the insurer's entire surplus (after deducting contributed or borrowed surplus funds) plus a reasonable present equity in its reserves and in all nonadmitted assets;

4. The policyholders entitled to participate in the purchase of stock or distribution of assets shall include all current policyholders and all existing persons who had been a policyholder of the insurer within three (3) years prior to the date such plan was submitted to the Commissioner;

5. The plan gives to each policyholder of the insurer as specified in paragraph 4 of this subsection, a preemptive right to acquire his proportionate part of all of the proposed capital stock of the insurer, within a designated reasonable period, and to apply upon the purchase thereof the amount of his equity in the insurer as determined under paragraph 3, above;

6. Shares are so offered to policyholders at a price not greater than to be thereafter offered to others nor at more than double the par value of such shares;

7. The plan provides for payment to each policyholder not electing to apply his equity in the insurer for or upon the purchase price of stock to which preemptively entitled, of cash in the amount of not less than fifty percent (50%) of the amount of his equity not so used for the purchase of stock, and which cash payment together with stock so purchased, if any, shall constitute full payment and discharge of the policyholder's equity as an owner of such mutual insurer; and

8. The plan, when completed, would provide for the converted insurer paid-in capital stock in an amount not less than the minimum paid-in capital required of a domestic stock insurer transacting like kinds of insurance, together with surplus funds in amount not less than one-half (1/2) of such required capital.

Laws 1957, p. 312, § 2130.

§36-2132. Reinsurance, stock insurers.

A. A domestic stock insurer may accept reinsurance for the same kind of insurance and within the same limits as it is authorized to transact direct, unless such reinsurance is prohibited by its articles of incorporation.

B. A domestic stock insurer may reinsure all or substantially all its business in force, or substantially all of a major class thereof, with another insurer by an agreement of bulk reinsurance; but no such agreement shall become effective unless filed with and approved in writing by the Commissioner.

C. The Commissioner shall approve such agreement within a reasonable time after such filing unless the Commissioner finds that the agreement would substantially reduce the protection or service to the policyholders of the insurer. If the Commissioner does not approve the agreement, he shall so notify the insurer in writing specifying his reasons therefor.

Amended by Laws 1988, c. 55, § 1, eff. Nov. 1, 1988.

§36-2133. Mergers and consolidations, mutual insurers.

A. A domestic mutual insurer shall not merge or consolidate with a stock insurer.

B. A domestic mutual insurer may merge or consolidate with another mutual insurer in accordance with procedures prescribed by general laws applying to corporations formed for profit, except as hereinbelow provided.

C. The plan and agreement for merger or consolidation shall be submitted to and approved by at least two-thirds (2/3) of the members of each mutual insurer involved voting thereon at meetings called for the purpose pursuant to such reasonable notice and procedure as has been approved by the Commissioner.

D. No such merger or consolidation shall be effectuated unless in advance thereof the plan and agreement therefor have been filed with and approved in writing by the Insurance Commissioner. The Commissioner shall give such approval within a reasonable time after such filing unless he finds such plan or agreement:

1. Inequitable to the policyholders of any domestic insurer involved; or

2. Would substantially reduce the security of and service to be rendered to policyholders of the domestic insurer in Oklahoma or elsewhere.

E. If the Commissioner does not approve such plan or agreement, he shall so notify the insurer in writing, specifying his reasons therefor.

Laws 1957, p. 313, § 2133.

§36-2134. Reinsurance, mutual insurers.

A. A domestic mutual insurer may accept reinsurance for the same kinds of insurance and within the same limits as it is

authorized to transact direct unless such reinsurance is prohibited by its articles of incorporation.

B. A domestic mutual insurer may reinsure all or any part of its business in force, or all or any part of a major class thereof, with another insurer, stock or mutual, by an agreement or reinsurance treaty. Any reinsurance of all its business or all of a major class of its business shall be subject to the approval of the Insurance Commissioner.

Laws 1957, p. 313, § 2134.

§36-2135. Mutual member's share of assets on liquidation.

A. Upon any liquidation of a domestic mutual insurer, its assets remaining after discharge of its indebtedness, policy obligations, repayment of contributed or borrowed surplus, if any, and expenses of administration, shall be distributed to existing persons who were its members at any time within thirty-six (36) months next preceding the date such liquidation was authorized or ordered, or date of last termination of the insurer's certificate of authority, whichever date is the earliest.

B. The distributive share of each such member shall be in the proportion that the aggregate premiums earned by the insurer on the policies of the member during the combined periods of his membership bear to the aggregate of all premiums so earned on the policies of all such members. The insurer may make a reasonable classification of its policies so held by such members and a formula based upon such classification for determining the equitable distributive share of each such member. Such classification and formula shall be subject to the approval of the Commissioner.

C. Subsections A and B above shall not apply to any mutual which, prior to July 1, 1957, has provided for any other method of liquidation through its articles and bylaws, and which have been approved by the then Insurance Commissioner.

Laws 1957, p. 313, § 2135.

§36-2201. Short title.

Sections 58 through 66 of this act shall be known and may be cited as the "Oklahoma Medical Professional Liability Trusts Act". Added by Laws 2004, c. 368, § 58, eff. July 1, 2004.

§36-2202. Definitions.

As used in the Oklahoma Medical Professional Liability Trusts Act:

1. "Allied health care professional" shall mean a physician's assistant, a certified registered nurse anesthetist or a nurse practitioner who is duly licensed by the appropriate licensing entity of the state and is supervised or employed by a physician and/or health care institution;

2. "Association" shall mean a nonprofit corporation that has been in continuous existence for a period of at least ten (10) years, the purpose of which is to federate into one organization all duly licensed physicians, allied health care professionals and/or health care institutions in this state;

3. "Commissioner" shall mean the Insurance Commissioner;

4. "Department" shall mean the Insurance Department;

5. "Health care institutions" shall mean hospitals, outpatient treatment facilities and facilities licensed pursuant to the Nursing Home Care Act;

6. "Medical professional liability claim" shall mean a claim or cause of action against a physician and/or a health care institution for treatment, lack of treatment, or other claimed departure from accepted standards of health care or safety which proximately results in injury to or death of the patient, whether the patient's claim or cause of action sounds in tort or contract;

7. "Physician" shall mean a doctor of medicine or osteopathy legally authorized to practice medicine and surgery in this state;

8. "Insureds" shall mean the physician, allied health care professional and health care institution members of an association that have medical professional liability coverage through the trust. "Insureds" shall also include entities and individuals specified in subsection C of Section 60 of this act if authorized by the trust; and

9. "Trust" shall mean a medical professional liability trust created pursuant to the Oklahoma Medical Professional Liability Trusts Act.

Added by Laws 2004, c. 368, § 59, eff. July 1, 2004.

§36-2203. Creation of trust - Conditions - Entities insured - Law governing reserves and surplus - Conversion of domestic stock insurers.

A. An association may create a trust to self-insure physicians, allied health care professionals or health care institutions against medical professional liability claims and related risks upon complying with the following conditions:

1. Establishment of a trust to provide coverage against medical professional liability claims and related risks;

2. Employment of appropriate professional staff and consultants for program management and purchase of such administrative services as may be required;

3. The trust investment powers and limitations shall be the same as those of any Oklahoma domestic casualty insurance company; and

4. Performance of all acts necessary or desirable to the conduct of the business of a medical professional liability insurer.

B. A trust may purchase, on behalf of the members of the organizing association, specific excess insurance, aggregate excess insurance, and reinsurance, as in the opinion of the trustee are necessary. A trust is further authorized to purchase risk management services as may be required and pay claims that arise under any deductible provisions.

C. If the terms of the trust so authorize, the trust may insure the following entities against medical professional liability claims and related risks:

1. Organizations or associations in which physicians, allied health care professionals or health care institutions are qualified members;

2. Entities that own or operate otherwise qualified health care institutions under the Oklahoma Medical Professional Liability Trusts Act;

3. Physicians' professional practice entities; and

4. Any person for whose acts or omissions an insured may be held legally responsible.

D. Laws of this state and the provisions of any chapters, articles or sections of Title 36 of the Oklahoma Statutes related to required amounts of reserves and surplus are declared inapplicable to a trust organized and operated under the Oklahoma Medical Professional Liability Trusts Act, except as provided in the Oklahoma Medical Professional Liability Trusts Act.

E. A licensed domestic stock insurer that prior to the effective date of this act writes physicians', allied health care professionals' or health care institutions' medical professional liability insurance and is owned wholly by an association shall be entitled to convert to a trust by:

1. Filing a plan, statement of conversion and trust instrument with the Commissioner. The plan, statement of conversion and trust instrument shall list all conditions to be fulfilled by a designated date, upon which such conversion will be effective, and all base rates to be charged by the trust;

2. Approval by vote or written consent of three-fourths (3/4) of the board of directors or trustees of the insurer's parent association;

3. Creation of a trust by the insurer's parent association;

4. Transfer of the assets and liabilities of the insurer to the trust;

5. Upon ninety (90) days' prior written notice to affected policyholders, replacement of the insurer's outstanding policies by the trust; and

6. Surrender or divesture for reasonable consideration of the insurer's license.

Added by Laws 2004, c. 368, § 60, eff. July 1, 2004.

§36-2204. Statements and reports - Taxes, fees and penalties.

A. A medical professional liability trust shall file the following items with the Commissioner:

1. Within forty-five (45) days after the end of each of the first three quarterly periods of each fiscal year, a statement of the assets and liabilities of the trust as of the end of the quarterly period, a statement of the revenue and expenditures of the trust, and a statement of the changes in corpus of the trust for the period, in each case accompanied by a certificate to the effect that the statements were prepared from the official books and records of the trust;

2. Within ninety (90) days after the end of each fiscal year, a statement of the assets and liabilities of the trust as of the end of that year, a statement of the revenue and expenditures of the trust, and a statement of the changes in corpus of the trust for that year, in each case accompanied by a certificate signed by a firm of independent certified public accountants indicating that the firm has conducted an audit of those statements in accordance with generally accepted auditing standards and indicating the results of the audit;

3. The independently audited annual financial statement of the trust by June 1 of each year;

4. The closed claim reports as are required pursuant to Sections 6810 through 6816 of Title 36 of the Oklahoma Statutes;

5. Rates and forms within thirty (30) days after issuance of the first policy and within thirty (30) days after any changes to the previously filed rates and forms; and

6. Any amendment to the trust instrument within thirty (30) days of making the amendment.

B. A trust shall, annually, on or before the first day of March, report under oath to the Commissioner, the total amount of direct written consideration received from the membership during the preceding calendar year, or since the last return of such considerations was made by such trust.

1. A trust shall pay to the Department, on or before March 1, an annual tax on all direct written considerations, after all returned considerations are deducted for the privileges of having written, continued and/or serviced contracts of indemnity except considerations paid by any governmental agency or instrumentality. The rate of taxation shall be two and twenty-five one-hundredths percent (2.25%). If any trust fails to remit such taxes in a timely manner, it shall remain liable therefor together with interest thereon at an annual rate equal to the average United States Treasury Bill rate of the preceding calendar year as certified by the State Treasurer on the first regular business day in January of each year, plus four (4) percentage points.

2. For any trust taxed pursuant to this section, the annual tax shall be in lieu of all other state taxes or fees, except the taxes and fees of any subdivision or municipality of the state and except ad valorem taxes. Any trust failing to make such returns and payments promptly and correctly shall forfeit and pay to the Commissioner, in addition to the amount of said taxes and fees and interest, the sum of Five Hundred Dollars (\$500.00) or an amount equal to one percent (1%) of the unpaid amount, whichever is greater; and the trust so failing or neglecting for sixty (60) days shall thereafter be debarred from transacting any business in this state until said taxes, fees and penalties are fully paid.

3. All taxes, fees and penalties collected under this section shall be reported and disbursed by the Commissioner and appropriated pursuant to the provisions of Section 312.1 of Title 36 of the Oklahoma Statutes.

Added by Laws 2004, c. 368, § 61, eff. July 1, 2004.

§36-2205. Trust instrument - Mandatory provisions.

In addition to the requirements of Section 60 of this act, the trust instrument shall provide:

1. That there shall be a minimum period during which any insured must participate in the trust;
2. That all insureds shall execute a participation agreement;
3. That the trustee shall be an individual or an institution such as a bank, insurance company or other appropriate entity;
4. A preliminary assessment of all insureds for initial expenses necessary to commence operation;
5. For establishment of necessary facilities;
6. Details of the management of the trust;
7. Procedures for assessment of all insureds to defray losses and expenses;
8. Description of commission arrangements;
9. Description of reasonable and objective underwriting standards;
10. Procedures for and description of acceptance and cession of reinsurance;
11. Procedures for and descriptions of appointment of servicing carriers or other servicing arrangements; and
12. Procedures for determining amounts of insurance to be provided by the trust.

Added by Laws 2004, c. 368, § 62, eff. July 1, 2004.

§36-2206. Minimum reserves and surplus.

The total of the reserves and surplus of a trust organized under the Oklahoma Medical Professional Liability Trusts Act, in excess of the amount necessary to support the trust's retention, must equal or

exceed forty percent (40%) of a range of values that makes reasonable provision for losses and loss expenses.

Added by Laws 2004, c. 368, § 63, eff. July 1, 2004.

§36-2207. Guaranty funds - Membership or financial contribution to or benefit from.

No trust created pursuant to the Oklahoma Medical Professional Liability Trusts Act shall be permitted to join or contribute financially to any insurance insolvency guaranty fund or similar entity, nor shall any trust or its insureds receive any benefit from any insurance guaranty fund or similar entity for claims made against the trust or its insureds.

Added by Laws 2004, c. 368, § 64, eff. July 1, 2004.

§36-2208. Duties of Commissioner - Review and evaluation - Study and analysis of cost of administration.

A. The Commissioner shall annually review negotiations between the trust and any entity to provide administrative, claim, underwriting or claim management services or excess insurance, aggregate excess insurance and reinsurance to the trust.

B. The Commissioner shall, at least twice yearly, review and evaluate each category of operations of the trust or association as follows:

1. Underwriting policies and activities, including all new applications for coverage, as well as all decisions regarding denial of new policies and surcharges on or nonrenewal of existing insureds;

2. Summaries of all claims activities, including number of claims filed, lawsuits filed, resolution of closed claims and lawsuits, amounts paid in settlements, jury verdicts, defense attorney fees, expert witness costs and other defense costs;

3. Consumer satisfaction with quality of service by the trust or its agents;

4. Investment activities;

5. All filed base rates and proposed rate increases; and

6. All risk-management activities, including continuing education and counseling of insureds.

C. The Commissioner shall further study and analyze the cost of administration of the trust to determine how its administrative costs compare to the administrative costs of other medical professional liability trusts and insurers providing medical liability coverage. The Commissioner shall submit a report of the Commissioner's study to the Governor, the President Pro Tempore of the Senate and the Speaker of the House of Representatives no later than February 1 of each year.

D. The trust shall provide the Commissioner with policy changes, rate changes, rules proposed by the trust and changes to

the trust instrument prior to implementation of policy changes, rate changes, proposed rules and changes to the trust instrument within thirty (30) days of implementation of such changes.
Added by Laws 2004, c. 368, § 65, eff. July 1, 2004.

§36-2211. Repealed by Laws 2013, c. 227, § 7, eff. Nov. 1, 2013.

§36-2401. Mutual benefit associations legalized.

All associations or companies or corporations doing an assessment life, health or accident insurance business in this state on the first day of January, 1925, on the assessment or mutual benefit plan, known as group or circle associations, or otherwise, and defined in this article as mutual benefit associations, are, by this article, legalized, ratified and confirmed and said associations, companies or corporations may continue to do business in this state if they comply with this article through their charters and bylaws and they accept the conditions of and, in other respects, comply with the provisions thereof. The conditions of the validation of said associations, companies or corporations, and their authority to do business in this state under certain restrictions, are hereinafter prescribed.
Laws 1957, p. 314, § 2401.

§36-2402. Formation - Prerequisites to transaction of business - Articles of association.

Any number of persons, being citizens of the United States, not less than seven, five of whom shall also be citizens and residents of the state of Oklahoma, desiring to form a mutual benefit association, may associate themselves together and effect such organization in the manner provided in this section and as otherwise provided in this article for reorganization of associations now doing business in this state, and not otherwise. Articles of association shall be prepared in triplicate in the manner hereinafter provided, and submitted to the Insurance Commissioner for approval. If the name selected for an association is not the same or so near the same as that of another association or corporation doing business in this state as to cause confusion in the minds of the people, and the objects of the association conform to the provisions of this article, the Insurance Commissioner shall endorse on the back of each copy of said articles of association the fact that the Commissioner has approved the same. Before the Insurance Commissioner shall approve such articles of association, it shall be shown to the Commissioner by the sworn statement of one or more of the proposed incorporators that at least one thousand persons have signed, in good faith, applications for benefit membership in such proposed association, and paid to the proper one of such proposed incorporators the amount of one death or mortuary

collection, by whatever name it may be called, and that such money is deposited with some bank or trust company and is held for the special purpose named. For such examination and approval of the articles of association herein mentioned, the Insurance Commissioner shall charge and receive a fee as stated in Section 321, Article 3 of this title. Provided, however, that before such incorporators, or any of them, or any person or persons, shall solicit members or collect any money whatever from any applicant in an association formed, or to be formed, under this article, they shall first furnish to the Insurance Commissioner a surety bond running to the State of Oklahoma, to be approved by the Commissioner, in the sum of Five Thousand Dollars (\$5,000.00) Dollars, conditioned that all sums collected, or to be collected, from applicants for benefit membership in such association will be promptly returned to respective applicants in case the articles of incorporation are not approved or no certificate of incorporation is granted within one (1) year from the date of the filing of such bond, or in case the association fails to accept said charter and in good faith conduct the business of a mutual benefit association authorized thereby. Upon the filing of said bond, the Insurance Commissioner shall issue a certificate to that effect, showing that the person or persons named therein are authorized to solicit members in such proposed association and to collect dues and assessments in advance. When the foregoing conditions are complied with and the articles of association are approved by the Insurance Commissioner, as hereinbefore provided, one copy thereof shall be filed with the Secretary of State, whereupon the said Secretary shall issue a certificate of incorporation and affix the Seal of the State thereto, and one copy, approved as hereinbefore provided, shall be delivered to the incorporators of such association, and the third approved copy of such articles shall be filed with the Insurance Commissioner. Such articles of association shall be substantially in the following form:

First. The preamble shall name the incorporators and give the residence of each and the fact of their citizenship, as herein required, and express their desire to incorporate a mutual benefit association in accordance with and under the provisions of this article, making definite reference to the same.

Second. Article I shall give the name of the association.

Third. Article II shall state the location of the principal office of the association.

Fourth. Article III shall state the objects of the association and the plans by which these objects are to be carried out, including the extreme limit of age of persons to whom benefit certificates may be issued, which limit of age shall not exceed seventy-two (72) years.

Fifth. Article IV shall state the names of the persons selected to manage the business or prudential affairs of the association for the first term, for which such persons are to be elected, the title of all officers and the names of such officers, with their residence, if they have been selected.

Sixth. Article V shall contain a description of the corporate seal adopted by such association, together with an impress of the same.

The articles of association shall be signed and acknowledged by each of the incorporators.

Added by Laws 1957, p. 314, § 2402, operative July 1, 1957. Amended by Laws 2010, c. 215, § 1, eff. Nov. 1, 2010.

§36-2403. Associations carried on for benefit of members -
Provision of benefits - Application of other laws.

A. Associations, companies or corporations organized as mutual benefit associations shall be carried on for the benefit of their members or their beneficiaries and not for profit, and shall make provisions for the payment of benefits in case of death and make provision for payment of benefits in case of permanent physical disability, as a result of accident, or old age, provided that the period of life at which the payment of physical disability benefits on account of old age is to commence, shall not be under seventy (70) years, all subject to compliance by its members with its constitution and bylaws. The funds from which the expenses, benefits, aids and other charges of such associations shall be defrayed shall be derived from assessments and dues collected from its members, provided that such association may if so stipulated in its bylaws as they now exist or as they may be hereafter amended, make provision for the payment of old age benefits at age seventy (70) or more, regardless of disability by levying special old age benefit assessments, beginning at an age of not less than fifty (50) years, in such sum and at such times as the association may determine to be necessary to provide an old age benefit fund sufficient to meet the promised old age benefit when the same matures, but such fund shall be separately maintained and used for no other purpose. The payment of death benefits shall be confined to wife, husband, relative by blood or marriage, children by legal adoption, to a person or persons dependent upon the member, or to his or her estate; provided, that if after the issuance of the original certificate the member shall become dependent upon a charitable institution, he or she shall have the privilege, with the consent of such association, to make such institution his or her beneficiary. Within the above restrictions each member shall have the right to designate his or her beneficiary, and, from time to time, have the same changed in accordance with the laws, rules and regulations of the association and no beneficiary shall have or

obtain any vested interest in any death benefit until the same has become due and payable upon the death of said member; provided, that any association may, by its laws, further limit the scope of beneficiaries with the above classes. And such association may create, maintain, disburse, and apply reserve or emergency funds in accordance with its constitution and bylaws. The term "mutual benefit association" whenever used in any law of this state shall be construed to mean association such as is defined by this section.

B. The provisions of this article apply only to mutual benefit associations and such associations shall be governed by this article to the extent provided herein. Such associations shall be exempt from all other provisions of the insurance laws of this state except that the provisions of Articles 1 (Scope of Title), 3 (Insurance Department and Insurance Commissioner), 12 (Unfair Practices and Frauds), 16 (Investments), 17 (Administration of Deposits), 18 (Rehabilitation and Liquidation), 44 (Individual Accident and Health Insurance) and Sections 4002, 4024, 4028 and 4029 of Article 40 (Life Insurance and Annuities) shall apply to such associations to the extent that such provisions are not in conflict with the provisions of this article. No law relating to insurance hereafter enacted shall apply to such associations unless they be expressly designated therein.

Added by Laws 1957, p. 315, § 2403, operative July 1, 1957. Amended by Laws 2006, c. 264, § 52, eff. July 1, 2006.

§36-2404. Provisions applicable to mutual benefit associations.

A. The following provisions are made applicable to mutual benefit associations:

1. The bylaws of such associations shall provide for periodical meetings of the members and how special meetings may be called. At such meetings each member shall be entitled to vote on all questions arising, either in person or by proxy, and such proxy may be given in the application for membership.

2. The bylaws shall provide for the calling of extra, increased or additional assessments when in the opinion of the board of directors such is necessary.

3. The bylaws may provide for the issuing of graded membership certificates to persons not to exceed seventy-two (72) years of age, and for the grading of rates of assessment according to the age of members; provided that the premium or assessment charged on policies or certificates insuring individuals over age seventy-two (72) shall not be less than the net rate produced by using the American Experience Table of Mortality with interest assumption at three and one-half percent (3 1/2%) plus ten percent (10%).

4. Such associations shall have the right to regulate and govern their affairs as provided and set forth in their respective bylaws, so long as such bylaws are not in conflict with any law of

this state. The membership shall be bound by the bylaws of the association as the same exist at the time of joining or as they may be amended in the future. Provided, no amendment to such bylaws affecting the policy contract or rate of contribution of the membership shall become valid and binding upon the membership unless notice of such proposed change in the bylaws is given each member of such association at least twenty (20) days prior to any annual meeting or special meeting of such association called to consider such proposed amendment and a certified copy thereof is filed with the Insurance Commissioner and approved by the Commissioner; provided further, that no notice of such proposed amendment shall be required if the same is adopted in compliance with any of the provisions of this article or a notice or order of the Insurance Commissioner made in pursuance thereof. Bylaws or amendments thereto, which are not in conflict with any of the provisions of this article, shall be approved by the Insurance Commissioner.

5. The affairs of such associations shall be conducted strictly in accordance with their respective bylaws herein provided for. Such bylaws duly certified to by the president and secretary shall be filed with the Insurance Commissioner, and copies of such, duly certified by the Commissioner, shall be received in evidence in all courts of this state.

6. In all actions against assessment insurance companies or against the bonds or bondsmen of such companies by any policyholder or beneficiary, it shall not be necessary to notify or summon the other policyholders or beneficiaries, but it shall be sufficient to bring such company into court by usual summons on the secretary or president or managing agent thereof, and in suits upon the bond by ordinary services as in other cases upon the several bondsmen sued.

7. In case the membership of any such association is divided into circles, classes or groups, upon the membership of which assessments are made to cover benefits or to replenish the mortuary or benefit fund, no benefit assessment shall be made upon any other circle, class or group to which the insured member does or did not belong to cover such benefit paid or to be paid.

B. No circle, class or group shall be established unless a sufficient number of members be placed therein and a regular benefit assessment collected therefrom will produce an amount sufficient to pay in full the face amount of the policy issued for which the assessment was levied, and each and every circle, class or group shall be maintained up to the number placed therein when such circle, class, or group was established; provided, that not more than one circle, class or group shall remain incomplete.

Added by Laws 1957, p. 316, § 2404, operative July 1, 1957. Amended by Laws 2010, c. 215, § 2, eff. Nov. 1, 2010.

§36-2405. Level or stipulated assessments - Definition - Policy to specify amount payable - Refusal to pay - Solvency - Legal reserve life insurance - Policy to make this section part thereof - Age limits - Beneficiaries - No mutual benefit associations formed hereafter.

Mutual benefit associations authorized to do business in this state, may provide for a level or stipulated weekly, monthly, quarterly, semiannual or annual assessment, and the following provisions are made specially applicable thereto:

1. Level rate assessment associations, companies or corporations are defined as those corporations granting insurance benefits on the assessment plan and which collect from their membership a level, stipulated monthly, quarterly, semiannual assessment or premium, which assessment or premium is not made contingent upon the happening of a certain event but is based upon stated periodical rates or charges estimated by the Board of directors to be sufficient for the payment of all claims and expenses.

2. Such associations shall specify in their policy or membership certificate forms the sum of money they promise to pay, which sum shall not be less than the face amount of the policy, and the number of days after satisfactory proof is filed when such payment will be made. Upon the occurrence of such contingency unless the contract shall have been void by fraud or by breach of its conditions, the corporation shall be obligated to the beneficiary for such payment at the time and in the amount specified in the policy or certificate. If such corporation shall refuse or fail to make such payment, after final judgment has been obtained upon each claim, the Insurance Commissioner shall notify the corporation not to issue any new policies or certificates until such indebtedness is fully paid; and no officer or agent of the corporation shall make, sign or issue any policy or certificate of insurance while such notice is in force.

3. Each such association or company shall be held to be legally solvent so long as its admitted assets are equal to or in excess of its matured liabilities.

4. Any association or company organized under the provisions of this article having admitted assets in its mortuary or reserve fund of at least One Hundred Thousand Dollars (\$100,000.00) in excess of its matured claim liabilities may write legal reserve life insurance and the provisions of paragraphs numbered 1, 7 and 8 of Section 1204, Article 12; Section 4029, Article 40, and Section 3610, Article 36 of this title shall be applicable to all insurance written on the legal reserve basis. The reserve on such business shall be held separate and apart from all other funds of the association or company and shall be computed upon a calculation which shall show a value not less than that shown in accordance with

the one-year preliminary term method based upon the American Experience Table of Mortality and three and one-half (3 1/2%) percent per annum, assuming an average risk exposure of six (6) months on all new policies issued within each calendar year shall be security for the legal reserve business only. Should such legal reserve become impaired by reason of excessive mortality or other cause, the board of directors of such association or company may levy additional assessments with which to make up such impairment. Every policy issued by reason hereof shall contain a provision making this section a part thereof. Provided, however, that any such association or company shall discontinue writing all types of new insurance in Oklahoma except legal reserve insurance within five (5) years after publishing legal reserve rates or having printed legal reserve policy forms. Any director, trustee, officer, or member of any such corporation, or any other person, may advance to the corporation any sum or sums of money necessary for the purpose of its business, or to enable it to comply with any of the requirements of the law, and such monies and such interest thereon as may have been agreed upon, not exceeding ten percent (10%) per annum, shall not be a liability or claim against the corporation or any of its assets except as to surplus earnings of such corporations and unless the obligation is in writing and duly acknowledged by the corporation, and a verified copy thereof is filed with the Insurance Commissioner. No commission or promotion expense shall be paid in connection with the advance of any such money to the corporation and the amount of such advance shall be reported in each annual statement filed with the Insurance Commissioner.

5. The provisions of this article placing the extreme limit of age of persons to whom policies may be issued at not to exceed seventy-two (72) years of age, shall not be applicable to insurance written upon the level rate plan outside the State of Oklahoma or the legal reserve plan in any state; provided that if the age of the insured has been incorrectly stated in the application for any policy issued by such association or company the face amount of said policy payable in event of a valid claim shall be such an amount as the premium paid by the insured to the association or company would have purchased at the true and correct age of the insured, at entry, on a basis of the published rates of the company applicable thereto.

6. Any individual, person, corporation, association or partnership with an insurable interest in the life of the insured may be a beneficiary of insurance written on either the level rate or legal reserve plan by an association or company operating under this article.

7. No mutual benefit association shall be formed after June 4, 1953, nor shall the Insurance Commissioner, after said effective date issue a permit to organize such an association to or approve any articles of incorporation of, any group of individuals desiring

to organize an association or company under the provisions of this article.

Added by Laws 1957, p. 317, § 2405, operative July 1, 1957. Amended by Laws 2010, c. 215, § 3, eff. Nov. 1, 2010.

§36-2406. Bond of custodian of funds - Nonpayment of benefits or claims - Emergency or reserve fund - Merger, consolidation or transfer of business and property.

Before any mutual benefit association shall do business in this state, under this article, it shall file in the office of the Insurance Commissioner, a bond of the official custodian of its fund executed by a surety company authorized to do business in this state, to be approved by the Commissioner, in the sum of Ten Thousand Dollars (\$10,000.00), to be conditioned for the prompt and full accounting and payment to the association of all of its funds entrusted to the officer and that are in his or her hands, and that he or she will faithfully comply with and perform all and singular the duties and obligations imposed upon him or her by the laws of this state. If any such association shall fail or refuse to make payment of any benefit or claim against the association, after final judgment has been obtained therefor, the Commissioner shall notify the association not to issue any new certificates or solicit new business until such indebtedness is fully paid, and no officer or agent of such association shall make, sign or issue any certificate of insurance while such notice is in force. Any such mutual benefit association hereafter organized under the laws of this state shall, before it completes its organization and receives a certificate of authority to do business in this state, produce and maintain an emergency or reserve fund of at least Ten Thousand Dollars (\$10,000.00), and such reserve or emergency fund produced and maintained as herein provided shall be invested in such securities as may be approved by the Commissioner, as required by law for the investment of such funds, and they shall be deposited with the Commissioner and be held by him or her in trust as an emergency fund for the benefit and protection of, and as security for, the certificate holders of such associations, their legal representatives or beneficiaries, and they shall have a lien to the extent of any valid claim arising out of a valid certificate, after such claim has been allowed by the association or established by a final judgment of a court of competent jurisdiction. Such securities as are deposited with the Commissioner, pursuant to this article, shall be part of the admitted assets of the association depositing the same. Two or more such associations authorized to do business in this state where one or all of them have been authorized under the laws of this state, may merge, unite or consolidate, or may cause the business and property, in whole or in part of one or more of the associations to be transferred to one of such

associations, or to any insurance association, company or corporation licensed to do business in this state, or to any person or persons: provided, however, before doing so, they shall submit to the Commissioner their agreement relating thereto, and, thereupon, he or she shall approve the same if he or she is satisfied that such merger, consolidation or transfer will not be prejudicial to the rights of the members and that such association can comply with the terms and conditions prescribed by law for the conduct and operation thereof.

Added by Laws 1957, p. 319, § 2406, operative July 1, 1957. Amended by Laws 2014, c. 275, § 10, eff. Nov. 1, 2014.

§36-2407. Permit to do business; fee; filing of copies of certificates, application blanks and bylaws.

A. The Insurance Commissioner, upon the application of any mutual benefit association having the right to do business in this state, as provided in this article, shall issue to such association a permit in writing, authorizing such association to do business in this state until the last day of February following the date of issuance of the license, for which permit or certificate and all proceedings in connection therewith such association shall pay the said Insurance Commissioner the fees and licenses therefor stated in Section 321, Article 3 of this Code; provided, that the form of certificates to be issued, copy of application blanks, and a certified copy of the bylaws shall be filed with the Insurance Commissioner, and, if the same conforms to the charter of such association and the provisions of this article, the Insurance Commissioner shall approve the same.

B. No such association shall act as an insurer and no such association shall transact insurance in this state except as authorized by a subsisting authority granted to it by the Insurance Commissioner.

Laws 1957, p. 319, § 2407.

§36-2408. Reincorporation of existing associations; admission of foreign corporations or associations.

Any domestic life or accident corporation, company or association existing or doing business in this state at the time this article takes effect, may by a vote of a majority of its board of directors or trustees, accept the provisions of this article and amend its articles of incorporation to conform to the same, so as to cover any and all of the provisions and privileges of this article the same as if it had been originally incorporated thereunder, and it shall file amended articles of incorporation in the office of the Secretary of State, a certified copy of which shall be filed with the Insurance Commissioner, and shall thereafter perpetually enjoy the same and be deemed to have incorporated under the article.

Reincorporation, however, shall in no way annul, modify or change any of the existing contracts and liabilities of such corporation, company or association, and any and all such contracts and liabilities shall continue in force and effect the same as though such corporation, company or association had not reincorporated or qualified under this article, and neither shall such reincorporation in any way prejudice, impede, or impair any rights or pending action or proceeding previously acquired; provided, however, that nothing herein shall prevent any of the members of such corporations, companies or associations from accepting and coming under the terms and conditions of such reincorporation and the bylaws of such association, if they desire to do so. Assessment corporations or associations organized under the laws of another state or country may be admitted to transact business in this state, upon proper application to the Insurance Commissioner, whenever, in his opinion, its financial condition is sound and its plan of operation such as to meet the requirements of this article. Such associations, with their applications, shall file a copy of their articles of incorporation or charter, bylaws, policy forms, rates, application blanks and other forms required by the Commissioner, together with a copy of the last annual statement and a twenty thousand-dollar bond, conditioned for the prompt payment of all assessments to parties or beneficiaries of such company, and shall pay the fees and licenses required by Article 3 of this Code. There shall also be filed a power of attorney, designating agent for service of process in form as now required by legal reserve life insurance companies. If all requirements are met, the Insurance Commissioner shall issue to such associations a certificate or license, authorizing it to transact business in this state, which authority shall expire on March first following and be renewed on that date annually so long as such association meets the requirements of this article.

Laws 1957, p. 320, § 2408.

§36-2409. Agents - Notice of appointment.

No mutual benefit association shall employ paid agents without first filing notice of appointment with the Insurance Commissioner and paying the fees therefor stated in Section 348.1, Article 3 of this Code; provided, that nothing herein shall prevent such associations granting members inducements to procure new members, as provided by law relating to fraternal beneficiary associations.

Added by Laws 1957, p. 320, § 2409, operative July 1, 1957. Amended by Laws 2006, c. 264, § 53, eff. July 1, 2006.

§36-2410. Benefits not liable to attachments.

The money or other benefit to be paid, provided or rendered by any association authorized to do business under this article, shall not be liable to attachment by trustee, garnishee or other process.

Laws 1957, p. 320, § 2410.

§36-2411. Dues - Emergency fund - Additional assessments.

A. Every mutual benefit association doing business in this state under the provisions hereof shall by its bylaws provide for the payment by its members of sufficient dues to cover the expenses of conducting the business of such association and for such assessments as may be necessary to provide funds sufficient to pay the benefits to which its members shall be come entitled and also to establish an emergency fund of at least One Dollar (\$1.00) per annum, per One Thousand Dollars (\$1,000.00) death benefits with which to meet any unusual or unanticipated benefits or losses which may become due and payable, which emergency fund shall be available for use by the association as may be provided in its bylaws without regard to the group, class or circle whose members might have paid assessments therefor; provided, however, that two additional assessments for such emergency fund of at least One Dollar (\$1.00) per One Thousand Dollars (\$1,000.00) of death benefits shall be levied annually in these circles, classes or groups where and when it may be done in any calendar month in which no death benefit assessment or call for dues is made upon members of such circle, class or group; provided further, that such associations may pay death benefits in excess of seven per thousand in any such circle, class or group when the emergency fund to its credit shall be sufficient therefor; and provided further, that if any annual report of a mutual benefit association, as provided for in this article or an investigation of the Insurance Commissioner discloses the fact that the mortuary and emergency funds of such association will not be sufficient to pay the benefits or losses to which its members or their beneficiaries may be entitled during the succeeding biennial period, the Insurance Commissioner, taking into consideration the age of the members and any special provisions for meeting such benefits or losses or for replenishing its funds, may direct such association to make such additional assessments as may be necessary to meet the said benefits or losses during the succeeding biennial period. Out of the original membership fee charged every new member there shall be placed in the mortuary or emergency fund a sum sufficient to equal at least one maximum benefit assessment to which said member would be liable under his contract. Whenever the association shall use any portion of the mortuary or benefit funds to pay promised benefits payable therefrom said association shall for the purpose of replenishing, establishing or maintaining a mortuary or benefit fund of sufficient strength to enable the association to meet promptly all valid claims for benefit as they mature, levy an additional assessment or assessments for such fund; provided that the association shall not be required to levy such assessment until in the judgment of the executive officers of such

association such additional assessment is needed; provided, that associations which have a table of rates that are sufficient to meet the above requirements shall not be required to make the assessment provided for herein, upon members whose benefit certificates are based upon such rate table.

B. The fund referenced in this section comprised of assessments upon the members of One Dollar (\$1.00) per One Thousand Dollars (\$1,000.00) of death benefits need not be reported separately, but shall become a part of the general funds of the association provided books and records are kept on the collection and disbursement of same.

Added by Laws 1957, p. 320, § 2411, operative July 1, 1957. Amended by Laws 2010, c. 215, § 4, eff. Nov. 1, 2010.

§36-2412. Medical examination of applicant; warranties and certificates in lieu of examination; concealment or misrepresentation.

A. Applicants for membership in mutual benefit associations shall be required to pass a medical or physical examination, if required by the bylaws of the association; or benefit certificates may be issued upon the warranty by the applicant that the answers and statements to the questions as to the condition of health of the applicant and all statements and answers made or appearing in the application for a benefit certificate are true and are to be used as the basis and consideration upon which said benefit certificate is issued, provided, that in addition to the answers and representations of the applicant for membership, as herein provided, the applicant shall give the name and address of his or her family physician and shall if required by the association furnish to the association a certificate of such physician, or if the applicant has no family physician, a certificate of a licensed physician, that he knows the applicant and believes that the applicant is a good, insurable risk; provided, that if the family physician refuses to sign a certificate stating whether applicant is a good insurable risk, a certificate from some other licensed physician may be secured; and, provided, further, that the fee for such certificate shall not exceed fifty cents (\$0.50).

B. Any beneficiary, his agent or representative, under any policy or certificate issued by any association or company coming within this article, or any doctor, undertaker or other attendant, who shall knowingly conceal, withhold, or misrepresent any facts in any verified report or declaration under oath concerning the health, age, cause of death or other material information as to the deceased member or policy holder because of whose death or accident claim is being made, shall be guilty of perjury and shall be subject to the penalties therefor prescribed by law.

Laws 1957, p. 321, § 2412.

§36-2413. Reports; examination of records.

Every mutual benefit association doing business within this state under this article, shall on or before the last day of February, of each year, make and file with the Insurance Commissioner of this state, a report and a statement of its affairs, business and operations, during the year ending on the thirty-first day of December immediately preceding. Such annual report shall be on blanks prepared by the Insurance Commissioner, verified under oath by a duly authorized officer of such association, and shall, so far as applicable, be substantially as provided in Section 623, Article 6 of this Code.

B. No such association shall act as an insurer and no such association shall transact insurance in this state except as authorized by a subsisting authority granted to it by the Insurance Commissioner.

Laws 1957, p. 322, § 2413.

§36-2414. Funds; investments of.

No mutual benefit association which may do business in this state, under this article, shall invest any of its mortuary, reserve or emergency fund except in accordance with the laws of this state, relating to investment of funds of domestic stock insurance companies doing a similar business.

Laws 1957, p. 322, § 2414.

§36-2415. Annual meetings; quorum; vacancies; special meetings.

Mutual benefit associations shall hold annual meetings on a definite day in each year, to be fixed in their bylaws, for the election of officers thereof and to transact such other business as may properly come before such meetings, and due notice of such meetings shall be given to each member, and benefit certificates issued to each member after the passage of this article shall contain thereon a statement of the date when such meetings shall be held each year at their home office, and ten percent (10%) of the members of such association present in person or by proxy shall constitute a quorum for the purpose of transacting business. Such associations may, by bylaws provide for filling vacancies on the board of directors until the next regular annual meeting thereof and may provide for special meetings of the members.

Laws 1957, p. 322, § 2415.

§36-2416. Appeals from orders, rulings, or acts of insurance commissioner.

Any association doing business in this state, under the provisions of this article, which may be dissatisfied with any notice, order, ruling or act of the Insurance Commissioner, may

appeal from the same pursuant to the provisions of Article 3 of this Code.

Laws 1957, p. 322, § 2416.

§36-2417. Misdemeanor; violation of article.

Any officer of a corporation subject to the provisions of this article, and any person or agent representing such corporation, who shall transact, or attempt to transact, in any manner whatever, any business in this state until such corporation has complied with the provisions of this article, or any person who shall violate any of the provisions of this article shall be deemed guilty of a misdemeanor and upon conviction, shall be fined in any sum not less than One Hundred Dollars (\$100.00) nor more than Five Hundred Dollars (\$500.00).

Laws 1957, p. 322, § 2417.

§36-2418. Legal reserve life insurance company, conversion into; adoption of plan.

Any mutual benefit association may convert itself into a stock legal reserve life insurance company under an amended charter. The plan of conversion shall be adopted at any regular annual policyholders' meeting of such association. Amended articles of incorporation providing for such conversion shall be adopted at the same meeting and shall be in the form as set out in either Section 2105, Article 21 of this Code and shall provide for a minimum capital stock of One Hundred Thousand Dollars (\$100,000.00) or in the form of Section 2502, Article 25, of this Code, and shall provide for a minimum capital stock of Fifty Thousand Dollars (\$50,000.00); provided, however, such conversion may be accomplished by paying up twenty per cent (20%) of the capital required by either of such sections at the time of such reorganization and not less than twenty per cent (20%) additional of the required amount each year thereafter until the full amount has been paid in. In the event the capital stock is not increased as herein provided the same shall be deemed to be impaired and the Insurance Commissioner shall proceed against the company as provided by law in such cases.

Laws 1957, p. 322, § 2418.

§36-2419. Amended articles of incorporation; filing.

The amended articles of incorporation so adopted shall be filed with the Secretary of State.

Laws 1957, p. 323, § 2419.

§36-2420. Policyholders; rights to purchase stock; sale of stock not purchased.

If such mutual benefit association be converted into a stock legal reserve life insurance company each and every policyholder or

certificate holder shall have the exclusive right for thirty (30) days after the conversion is approved at the policyholders' meeting and the mailing of the notice thereof to purchase that proportion of the total stock offered for sale as the amount of his insurance bears to the association's total insurance in force at the time of conversion. Any stock not purchased by the policyholders may then be sold by the board of directors.
Laws 1957, p. 323, § 2420.

§36-2421. Reorganization and conversion complete when; rights of reorganized corporations.

When such mutual benefit association shall have complied with the provisions of this article and shall have received from the Insurance Commissioner a certificate of authority to transact business in this state as a legal reserve life insurance company, its reorganization and conversion into such legal reserve company shall be complete. Such reorganized and converted corporation shall succeed to and become invested with all and singular the rights, privileges, franchises, and all property, real, personal or mixed, all debts due on any account and all other things in action theretofore belonging to such mutual benefit association, and all property, rights, privileges, franchises and all and every other interest including title to any real estate by deed or otherwise vested in such former mutual benefit association shall vest in such reorganized and converted corporation.
Laws 1957, c. 323, § 2421.

§36-2422. Creditors' rights; liens; contracts; pending suits.

The rights of creditors and all liens upon the property of the former mutual benefit association shall be preserved unimpaired and all debts, liabilities, contracts and duties of the former mutual benefit association shall thenceforth attach to the reorganized and converted organization, and such reorganized and converted corporation shall be obligated to carry out and perform all of the obligations of every kind and character owing by the former mutual benefit association to the holders of its policies or certificates; and said policies or certificates shall be administered in accordance with the provisions of the law in force at the time said policies were issued. Any pending suits wherein the former mutual benefit association was a party shall be unaffected by the conversion thereof, and shall be prosecuted by or against such reorganized and converted corporation the same as if the conversion had not taken place.
Laws 1957, p. 323, § 2422.

§36-2501. Organization authorized; purpose.

Any number of persons, not less than five, a majority of whom being citizens and residents of the State of Oklahoma, may associate themselves and form a company, for the purpose of making insurance on the lives of individuals, with a stipulated premium, as defined and regulated herein, and may write life insurance and/or accident and health insurance.

Laws 1957, p. 323, § 2501.

§36-2502. Designation as corporators; articles of agreement; contents; approval by insurance commissioner; filing and recording.

The persons mentioned in Section 2501 shall be designated as corporators, and such persons shall associate themselves by articles of agreement in writing, duly signed and acknowledged, setting forth:

First: The corporate name of the proposed corporation, which shall not be the name of any corporation heretofore incorporated or doing business in this state for similar purposes, or any such imitation of such name calculated to mislead the public.

Second: The name of the city, town or county in which the principal office is located.

Third: The amount of the capital stock of the corporation, which shall not be less than Fifty Thousand Dollars (\$50,000.00), the number of shares into which it is divided, and the par value thereof, that the same has been bona fide subscribed, and actually paid up in lawful money of the United States, and is in the custody of persons named as the first board of directors, the name and place of the several shareholders and the number of shares subscribed by each.

Fourth: The number of the board of directors or managers, which shall be not less than five, their powers and duties, and the names agreed upon for the first year.

Fifth: The number of years the corporation is to continue.

Sixth: A statement that the company is formed for the purpose of carrying on the business of insurance under the provisions of this article. Said articles of agreement shall be submitted to the Insurance Commissioner, and if they are found to comply with the provisions of this article, he shall approve the same. When approved they shall be filed and recorded in the office of the Secretary of State, who shall issue a certificate of incorporation, upon the receipt of which such persons shall be a body corporate and politic, under the laws of this state.

Laws 1957, p. 324, § 2502.

§36-2503. Certificate of authority to do business - Deposit of securities with State Treasurer.

No such corporation, company or association shall commence the business of insurance until the Insurance Commissioner shall have

certified that it has complied with the provisions of this article, and is authorized to transact the business of insurance; provided, however, that every corporation incorporating or reincorporating under the provisions of this article shall deposit with the Commissioner securities in which insurance companies are allowed by law to invest, subject to the approval of the Insurance Commissioner, a sum not less than Twenty Thousand Dollars (\$20,000.00), before it shall commence business. The sum shall be a part of the insurance fund and an asset of the corporation. The securities deposited with the Commissioner pursuant to this section shall be held in trust as an emergency fund for the benefit and protection of and as security for the policyholders of such corporation, their legal representatives and beneficiaries. Added by Laws 1957, p. 324, § 2503, operative July 1, 1957. Amended by Laws 2014, c. 275, § 11, eff. Nov. 1, 2014.

§36-2504. Companies to which applicable; application of other laws; use of term "stipulated premium".

Any corporation, company or association issuing policies or certificates promising money or other benefits to a member or policyholder, or, upon his decease, to his legal representatives, or to beneficiaries designated by him, which money or benefit is derived from stipulated premiums collected in advance from its members or policyholders, and from interest and other accumulations, and wherein the money or other benefits so realized is applied to or accumulated solely for the use and purposes of the corporation as herein specified, and for the necessary expenses of the corporation, and the prosecution and enlargement of its business and which shall comply with all the provisions of this article, shall be deemed to be engaged in the business of life insurance and accident and health insurance upon the stipulated premium plan. It shall be unlawful for any corporation, company or association not having complied with the provisions of this article to use the term "stipulated premium" in its application or contracts, or to print or write the same in its policies, literature or advertisements.

Laws 1957, p. 324, § 2504.

§36-2505. Valuation of outstanding policies; computation.

Each and every company incorporated transacting business under the provisions of this article shall annually make valuations of all outstanding policies of life insurance as of December 31st of each year, computed upon a calculation which shall show a value not less than that shown in accordance with the one-year preliminary term method, based upon the American Experience Table of Mortality and three and one-half percent (3 1/2%) per annum, assuming an average risk exposure of six (6) months on all new policies issued within each calendar year.

Laws 1957, p. 325, § 2505.

§36-2506. Inapplicability to burial associations or assessment companies.

The provisions of this article shall not apply to burial associations or assessment companies.

Laws 1957, p. 325, § 2506.

§36-2507. Requisites of policy; liability on policy.

Every policy hereafter issued by any corporation, company or association doing business under the provisions of this article and promising any payments to be made upon a contingency provided for in this article, shall specify the sum of money which it promises to pay upon each contingency insured against and the time or times of payment after satisfactory proof of the happening of such contingency and unless the contract shall have been voided by fraud or breach of its conditions and warranties, the company shall be obligated to the beneficiaries of the insured for such payment at the time or times specified and to the amount due under the policy.

Laws 1957, p. 325, § 2507.

§36-2508. Personal liability.

No person shall incur any personal liability for the losses or liabilities of any corporation, company or association transacting business under the provisions of this article by reason of being a member or policyholder in such corporation.

Laws 1957, p. 325, § 2508.

§36-2509. Consolidation of companies; transfer or reinsurance of risks.

No stipulated premium insurance company or association organized under this article shall consolidate with another company or transfer or reinsure its risks with any other corporation, company or association or assume or reinstate the whole or any part of the risks of any other company or association, except with the approval of the Insurance Commissioner, and a majority of the stockholders present and voting at a regular or special meeting duly called.

Laws 1957, p. 325, § 2509.

§36-2510. Attachment or other process; benefits not subject to.

The money or other benefit, charity, relief or aid to be paid, provided or rendered by any corporation, company or association authorized to do business under this article, shall not be liable to attachment or other process, and shall not be seized, taken, appropriated or applied by any legal or equitable process, nor by operation of law, to pay any debt or liability of a policy or

certificate holder or of any beneficiary named in a policy or certificate.

Laws 1957, p. 325, § 2510.

§36-2511. Existing corporations; amendments of articles of incorporation; effect of reincorporation.

Any domestic life or accident and health corporation, company or association existing or doing business in this state on April 9, 1923, may, by the vote of a majority of its board of directors or trustees, accept the provisions of this article and amend its articles of incorporation to conform to the same, so as to cover and enjoy any and all the provisions and privileges of this article the same as if it had been originally incorporated thereunder, and it shall file such amended articles of incorporation in the office of the Secretary of State, a certified copy of which shall be filed with the Insurance Commissioner, and shall thereafter perpetually enjoy the same and be deemed to have been incorporated under this article. Reincorporation, however, shall in no way annul, modify or change any of the existing contracts and liabilities of such corporation, company or association, and any and all such contracts and liabilities shall continue in force and effect the same as though such corporation had not reincorporated or qualified under this article, neither shall such reincorporation in any way prejudice, impede or impair any pending action or proceeding or any rights previously acquired.

Laws 1957, p. 325, § 2511.

§36-2512. Amendment of articles of incorporation to conform to general insurance law.

Any domestic life or accident and health insurance corporation, company or association existing or doing business in this state under the stipulated premium plan law on April 9, 1923, may, by majority vote of its board of directors or trustees, accept the provisions of this article, the same as if it had originally been incorporated thereunder, and shall submit a record of the proceedings of its board of directors or trustees, together with the amended articles, to the Insurance Commissioner, for his examination and approval of the legal form thereof, and shall file such amended articles in the office of the Secretary of State and a certified copy of same in the office of the Insurance Commissioner, and deposit with the State Treasurer such securities as may be required of corporations originally incorporated under this article. Insurance corporations, companies and associations complying with the provisions of this section shall thereafter enjoy and exercise all of the rights and privileges accorded by law to companies originally incorporated under this article. Compliance with this section shall in nowise annul, modify or change any of the existing

contracts or obligations of the corporation, and any and all such contracts and liabilities shall continue in force and effect the same as if such corporation had not reincorporated under the provisions of this section. Compliance with the provisions of this section shall in no way prejudice, impede or impair any pending action, proceeding or rights previously acquired.

Laws 1957, p. 326, § 2512.

§36-2513. Statement filed annually with Insurance Commissioner.

The annual business of each and every corporation, company or association transacting business under the provisions of this article shall close on the 31st day of December, of each year, and it shall, within sixty (60) days thereafter, prepare and file in the office of the Insurance Commissioner, or other officer having supervision of insurance matters, a detailed statement, made on blanks furnished by the Insurance Commissioner, and verified under oath by the president and secretary of the company or association giving all information in detail that the Insurance Commissioner may require, so that its true financial condition may be known.

Laws 1957, p. 326, § 2513.

§36-2514. Relinquishment of business.

When any such corporation, company or association shall desire to relinquish its business in this state, the Insurance Commissioner shall, on application of such corporation under oath of its president or principal officer and secretary or actuary, give notice of such intention at least twice in a newspaper of general circulation published at the state capital. After such publication he shall deliver up to said corporation the securities, or any portion thereof, held by the State Treasurer belonging to such corporation upon being satisfied that all debts and liabilities of every kind are paid or provided for.

Laws 1957, p. 326, § 2514.

§36-2515. Representations; deemed material when.

No representation made in obtaining or securing a policy of insurance on the life or lives of any person, or persons, shall be deemed material, or render the policy void, unless the matter misrepresented shall have actually contributed to the contingency or event on which the policy is to become due and payable.

Laws 1957, p. 326, § 2515.

§36-2516. Foreign and alien companies.

No corporation, company, association or society organized under the laws of any other state or territory of the United States, or the District of Columbia, or foreign country shall transact business under the provisions of this article until it has received from the

Insurance Commissioner a certificate of authority to do business in this state, a duplicate of which shall be filed in his office. The Insurance Commissioner shall annually issue to such foreign corporation, company or association renewal certificates of authority to continue business, if it shall have fully complied with the provisions of this article, and if the Insurance Commissioner shall be of the opinion that any such corporation, company or association is not entitled to a renewal of a certificate of authority, he shall cite the same to appear, giving reasons therefor, and to show cause why the certificate of authority should be renewed, and unless the certificate of authority shall be renewed within thirty days after such hearing, such foreign corporation, company or association shall cease to do business in this state. No foreign corporation, company, association or society shall be authorized to transact any business authorized by this article within this state, unless it can furnish evidence satisfactory to the Insurance Commissioner that it has a reserve or emergency fund equal in amount to that required by this article, and the same is held for the benefit of policyholders only, and invested as required by the insurance laws of its home state.

Laws 1956, p. 326, § 2516.

§36-2517. Laws applicable.

A. The provisions of this article are applicable to limited stock life, accident and health insurers only.

B. To the extent not modified by the provisions of this article, limited stock life, accident and health insurers shall be subject to and governed by the other applicable provisions of this code.

C. No limited stock, life, accident and health insurers shall be authorized after the effective date of this act, nor shall the Insurance Commissioner after said effective date issue a certificate of authority for such limited stock, life, accident and health insurance business.

Laws 1957, p. 327, § 2517; Laws 1980, c. 185, § 6, eff. Oct. 1, 1980.

§36-2601. Corporations authorized - Powers.

A. Corporations may be organized not for profits under the laws of the State of Oklahoma, for the purpose of establishing, maintaining and operating a not-for-profit hospital service or indemnity plan, and/or a not-for-profit medical or indemnity plan, for the purpose of making contracts of insurance or indemnity, or for the purpose of making indemnity plan contracts, or for all such purposes, by complying with the provisions of this article and shall be exempt from all other provisions of the insurance laws and the

general corporation laws of this state, unless otherwise specifically provided herein.

B. Every corporation organized under the provisions of this article may, in the corporate name:

1. Sue and be sued;
2. Enter into contracts;
3. Prescribe qualifications and the manner and form of admission or withdrawal of members;
4. Have and use a common seal which may be changed or altered at pleasure;
5. Take, purchase, lease, hold or dispose of real or personal property in the corporate name, or in the name of trustees chosen by the board of directors;
6. Invest, loan, borrow money and incur debt, and engage in all forms of business transactions which are not inconsistent with the articles of incorporation or bylaws of the corporation, or with law;
7. Make all necessary rules and regulations concerning risks or hazards incurred, the premium rates to be used, and adjustment and payment of losses;
8. Insure, indemnify, and fix the compensation of directors and officers of the corporation and require bond for the faithful performance of duties by such directors and officers;
9. Exercise all such other powers as may be necessary to carry into effect the purpose or object of such corporation subject to the restrictions provided in this section;
10. Make or amend bylaws not inconsistent with law or provisions of the articles of incorporation, provided such bylaws shall fix the date and place of the annual meeting of members, shall designate the number of directors which shall not be less than five (5), and shall define the duties of the officers and fix the term of office of the directors and officers of such corporation; and
11. Make all further necessary provisions concerning the conduct of the business affairs of the corporation.

Amended by Laws 1988, c. 227, § 2, emerg. eff. June 20, 1988.

§36-2602. Application for certificate - Contents - Fee.

Such a corporation may issue contracts to its subscribers only when the Insurance Commissioner has, by certificate of authority, authorized it so to do. Application for such certificate of authority shall be made on forms supplied or approved by the Commissioner, containing such information as he shall deem necessary. Each application for such certificate of authority shall be accompanied by the fee prescribed by Article 3 (Insurance Department and Insurance Commissioner) of this Code and copies of the following documents:

1. Articles of incorporation;
2. Bylaws;

3. Proposed contracts, if any, between the applicant and participating hospitals and physicians, showing the terms under which service is to be furnished to subscribers;

4. Proposed contracts to be issued to subscribers;

5. A table of rates to be charged to subscribers;

6. Financial statement of the corporation, including the amounts of contributions paid or agreed to be paid to the corporation for working capital and the name or names of each contributor and the terms of each contribution; and

7. A statement of the area in which the corporation proposes to operate.

Added by Laws 1957, p. 327, § 2602, operative July 1, 1957. Amended by Laws 2006, c. 264, § 54, eff. July 1, 2006.

§36-2603. Certificate of authority; requirements.

The Insurance Commissioner shall issue a certificate of authority authorizing the applicant to issue contracts to its subscribers when it is shown to the satisfaction of the Commissioner that:

1. The applicant is established as a bona fide not-for-profit hospital service or indemnity corporation and/or a not-for-profit medical or indemnity corporation;

2. The contracts between the applicant and the participating hospitals, physicians, or other health care providers, if any, obligate each hospital, physician, or other health care provider executing the same to render service to which each subscriber may be entitled under the terms of the contract to be issued to the subscribers;

3. The amounts provided as working capital of the corporation are repayable, without interest, out of operating expenses;

4. The amount of money actually available for working capital is sufficient to carry on the plan for a period of six (6) months from the date of issuance of the certificate of authority; and

5. The applicant has secured contracts of participation from sufficient hospitals, physicians, or other health care providers to provide ample protection for its subscribers within the area proposed to be served by the applicant.

Amended by Laws 1988, c. 227, § 3, emerg. eff. June 20, 1988.

§36-2604. Deposit for protection of members.

A. Corporations governed by this article shall at all times have on deposit with the Insurance Commissioner sums as follows:

1. If newly formed under this article, the sum of Fifteen Thousand Dollars (\$15,000.00); or

2. If formed under prior law, such sum as was so required under such prior law.

Every such corporation shall deposit with the Commissioner, not later than the first day of each February, an amount equal to two percent (2%) of the gross subscriptions collected during the preceding calendar year, until the deposit of such corporation reaches a total of Twenty-five Thousand Dollars (\$25,000.00). All such deposits shall be held by the Commissioner in trust for the benefit and protection of the subscribers of the corporation making the deposit.

B. The deposit prescribed by this section shall be subject to withdrawal in whole or in part on the order of and as directed by the Insurance Commissioner, but may, with the approval of the Commissioner, be invested in bonds of the United States or of the State of Oklahoma, or any political subdivision thereof, or state warrants, which shall be assigned to the Commissioner and held by the Commissioner as provided for original deposits. The securities may, with the approval of the Commissioner, be exchanged for similar securities or cash of equal amount. Interest on securities so deposited shall be payable to the corporation depositing the same.

C. An unsettled final judgment, arising upon a certificate of participation against such a corporation, shall be a lien on the deposit prescribed by this section, subject to execution after thirty (30) days from the entry of final judgment. If the deposit is reduced thereby, it shall be replenished within ninety (90) days.

D. Upon the liquidation or dissolution of such corporation and the satisfaction of all its liabilities, any balance remaining in the deposit in the hands of the Commissioner and any other assets of the insurer shall be distributed to the holders of certificates of participation in good standing at the time proceedings for the liquidation or dissolution of the corporation were commenced, prorated according to the gross amount of subscriptions which have been paid on such certificates up to the time such proceedings were commenced.

Added by Laws 1957, p. 328, § 2604, operative July 1, 1957. Amended by Laws 2014, c. 275, § 12, eff. Nov. 1, 2014.

§36-2605. Service contracts.

Any such corporation may enter into contracts for the rendering or providing of hospital and/or medical service or indemnity to any of its members with any individuals licensed in any branch of the healing arts and/or licensed hospitals maintained or operated by individuals, partnerships, associations or corporations and hospitals maintained or operated by the state or its subdivisions. Any such corporation may contract with any domestic or foreign corporation or associations for the purpose of providing or rendering hospital or medical service or indemnity.

Amended by Laws 1988, c. 227, § 4, emerg. eff. June 20, 1988.

§36-2606. Filing of forms and rates; disapproval.

On and after the effective date of this Code no policy or contract providing for hospital service or indemnity or medical service or indemnity shall be issued or delivered to any person in this state, nor shall any application, rider or endorsement be issued in connection therewith, until a copy of the form thereof and classifications of risk and underwriting manual, and the rates pertaining thereto, have been filed with the Insurance Commissioner. Such filing shall be deemed approved unless disapproved by the Insurance Commissioner within sixty (60) days after the date of filing. If the Insurance Commissioner disapproves the policy or contract, application, rider or endorsement form, or classifications of risk and underwriting manual, said Commissioner shall make a written decision stating the reason or reasons therefor and shall deliver a copy thereof to the corporation and it shall be unlawful for any such corporation to use any such disapproved form in this state. Any such corporation shall have twenty (20) days from date of receipt of the notice of disapproval in which to request a hearing on such disapproval.

Amended by Laws 1988, c. 227, § 5, emerg. eff. June 20, 1988.

§36-2608.1. Directors.

A. The business and affairs of every corporation organized pursuant to the provisions of Article 26 of the Insurance Code shall be managed by or under the direction of a board of directors.

B. The board of directors shall consist of five (5) or more members. The number of directors shall be fixed by or in the manner provided for in the bylaws. Directors need not be members unless so required by the certificate of incorporation or the bylaws. The certificate of incorporation or bylaws may prescribe other qualifications for directors. Each director shall hold office until expiration of his term of office, or until his earlier resignation or removal. Any director may resign at any time upon written notice to the corporation. A majority of the total number of directors shall constitute a quorum for the transaction of business unless the certificate of incorporation or the bylaws require a greater number. Unless the certificate of incorporation provides otherwise, the bylaws may provide that a number less than a majority shall constitute a quorum which in no case shall be less than one-third (1/3) of the total number of directors. The vote of the majority of the directors present at a meeting at which a quorum is present shall be the act of the board of directors.

C. The board of directors, by resolution passed by a majority of the whole board, may designate one or more committees, each committee to consist of one or more of the directors of the corporation. The board may designate one or more directors as alternate members of any committee, who may replace any absent or

disqualified member at any meeting of the committee. The bylaws may provide that in the absence or disqualification of a member of a committee, the member or members thereof present at any meeting and not disqualified from voting, whether or not he or they constitute a quorum, may unanimously appoint another member of the board of directors to act at the meeting in the place of any such absent or disqualified member.

D. A member of the board of directors, or a member of any committee designated by the board of directors, in the performance of his duties, shall be fully protected in relying in good faith upon the records of the corporation and upon such information, opinions, reports or statements presented to the corporation by any of the corporation's officers or employees, or committees of the board of directors, or by any other person as to matters the member reasonably believes are within such officer's, employee's, committee's, or other person's competence and who have been selected with reasonable care by or on behalf of the corporation.

E. Unless otherwise restricted by the certificate of incorporation or bylaws:

1. Any action required or permitted to be taken at any meeting of the board of directors, or of any committee thereof may be taken without a meeting if all members of the board or committee, as the case may be, consent thereto in writing, and the writing or writings are filed with the minutes of proceedings of the board or committee;

2. The board of directors of any corporation organized in accordance with the provisions of Article 26 of the Insurance Code periodically may hold its meetings outside of this state;

3. The board of directors shall have the authority to fix the compensation of directors; and

4. Members of the board of directors of any corporation, or any committee designated by such board, may participate in a meeting of such board or committee by means of conference telephone or similar communications equipment by means of which all persons participating in the meeting can hear each other, and participation in a meeting pursuant to the provisions of this subsection shall constitute presence in person at such meeting.

Added by Laws 1988, c. 227, § 6, emerg. eff. June 20, 1988.

§36-2608.2. Officers.

A. Every corporation organized in accordance with the provisions of Article 26 of the Insurance Code shall have such officers with such titles and duties as shall be stated in the bylaws or in a resolution of the board of directors which is not inconsistent with the bylaws.

B. The corporation may secure the fidelity of any or all of its officers or agents by bond or otherwise.

C. A failure to elect officers shall not dissolve or otherwise affect the corporation.

Added by Laws 1988, c. 227, § 7, emerg. eff. June 20, 1988.

§36-2608.3. Indemnification and advancement of expenses of certain persons.

A. A corporation organized pursuant to the provisions of Article 26 of the Insurance Code shall have power to indemnify any person who was or is a party or is threatened to be made a party to any threatened, pending or completed action, suit or proceeding, whether civil, criminal, administrative or investigative, other than an action by or in the right of the corporation, by reason of the fact that he is or was a director, officer, employee or agent of the corporation, or is or was serving at the request of the corporation as a director, officer, employee or agent of another corporation, partnership, joint venture, trust or other enterprise, against expenses, including attorneys' fees, judgments, fines, and amounts paid in settlement actually and reasonably incurred by him in connection with such action, suit or proceeding if he acted in good faith and in a manner he reasonably believed to be in or not opposed to the best interests of the corporation, and, with respect to any criminal action or proceeding, had no reasonable cause to believe his conduct was unlawful. The termination of any action, suit or proceeding by judgment, order, settlement, conviction, or upon a plea of nolo contendere or its equivalent, shall not, of itself, create a presumption that the person did not act in good faith and in a manner which he reasonably believed to be in or not opposed to the best interests of the corporation, and, with respect to any criminal action or proceeding, had reasonable cause to believe that his conduct was unlawful.

B. A corporation organized pursuant to the provisions of Article 26 of the Insurance Code shall have the power to indemnify any person who was or is a party or is threatened to be made a party to any threatened, pending or completed action or suit by or in the right of the corporation to procure a judgment in its favor by reason of the fact that he is or was a director, officer, employee or agent of the corporation, or is or was serving at the request of the corporation as a director, officer, employee or agent of another corporation, partnership, joint venture, trust or other enterprise against expenses, including attorneys' fees, actually and reasonably incurred by him in connection with the defense or settlement of such action or suit if he acted in good faith and in a manner he reasonably believed to be in or not opposed to the best interests of the corporation and except that no indemnification shall be made in respect of any claim, issue or matter as to which such person shall have been adjudged to be liable to the corporation unless and only to the extent that the court in which such action or suit was

brought shall determine upon application that, despite the adjudication of liability but in view of all the circumstances of the case, such person is fairly and reasonably entitled to indemnity for such expenses which the court shall deem proper.

C. To the extent that a director, officer, employee or agent of a corporation has been successful on the merits or otherwise in defense of any action, suit or proceeding referred to in subsection A or B of this section, or in defense of any claim, issue or matter therein, he shall be indemnified against expenses, including attorneys' fees, actually and reasonably incurred by him in connection therewith.

D. Any indemnification under the provisions of subsection A or B of this section, unless ordered by a court, shall be made by the corporation only as authorized in the specific case upon a determination that indemnification of the director, officer, employee or agent is proper in the circumstances because he has met the applicable standard of conduct set forth in subsection A or B of this section. Such determination shall be made:

1. By the board of directors by a majority vote of a quorum consisting of directors who were not parties to such action, suit or proceeding; or

2. If such a quorum is not obtainable, or, even if obtainable a quorum of disinterested directors so directs, by independent legal counsel in a written opinion; or

3. By the members.

E. Expenses incurred by an officer or director in defending a civil or criminal action, suit or proceeding may be paid by the corporation in advance of the final disposition of such action, suit or proceeding upon receipt of an undertaking by or on behalf of such director or officer to repay such amount if it shall ultimately be determined that he is not entitled to be indemnified by the corporation as authorized by the provisions of this section. Such expenses incurred by other employees and agents may be so paid upon such terms and conditions, if any, as the board of directors deems appropriate.

F. The indemnification and advancement of expenses provided by or granted pursuant to the other subsections of this section shall not be deemed exclusive of any other rights to which those seeking indemnification or advancement of expenses may be entitled under any bylaw, agreement, vote of shareholders or disinterested directors or otherwise, both as to action in his official capacity and as to action in another capacity while holding such office.

G. A corporation shall have power to purchase and maintain insurance on behalf of any person who is or was a director, officer, employee or agent of the corporation, or is or was serving at the request of the corporation as a director, officer, employee or agent of another corporation, partnership, joint venture, trust or other

enterprise against any liability asserted against him and incurred by him in any such capacity, or arising out of his status as such, whether or not the corporation would have the power to indemnify him against such liability under the provisions of this section.

H. For purposes of this section, references to "the corporation" shall include, in addition to the resulting corporation, any constituent corporation, including any constituent of a constituent, absorbed in a consolidation or merger which, if its separate existence had continued, would have had power and authority to indemnify its directors, officers, and employees or agents, so that any person who is or was a director, officer, employee or agent of such constituent corporation, or is or was serving at the request of such constituent corporation as a director, officer, employee or agent of another corporation, partnership, joint venture, trust or other enterprise, shall stand in the same position under the provisions of this section with respect to the resulting or surviving corporation as he would have with respect to such constituent corporation if its separate existence had continued.

I. For purposes of this section, references to "other enterprises" shall include employee benefit plans; references to "fines" shall include any excise taxes assessed on a person with respect to an employee benefit plan, and references to "serving at the request of the corporation" shall include any service as a director, officer, employee or agent of the corporation which imposes duties on, or involves services, by such director, officer, employee, or agent with respect to an employee benefit plan, its participants, or beneficiaries; and a person who acted in good faith and in a manner he reasonably believed to be in the interest of the participants and beneficiaries of an employee benefit plan shall be deemed to have acted in a manner "not opposed to the best interests of the corporation" as referred to in this section.

J. The indemnification and advancement of expenses provided by or granted pursuant to this section, unless otherwise provided when authorized or ratified, shall continue as to a person who has ceased to be a director, officer, employee or agent and shall inure to the benefit of the heirs, executors and administrators of such a person. Added by Laws 1988, c. 227, § 8, emerg. eff. June 20, 1988.

§36-2609. Membership; voting; membership fees.

A. Corporations organized under this article shall be mutual corporations and every person who holds a policy or contract with the corporation shall be a member of the corporation and shall be entitled to one or more votes based upon the number of policies or contracts held, and such members may vote in person or by proxy.

B. Mutual corporations organized in accordance with the provisions of this article shall be entitled to charge and collect

initial membership fees or policy fees, or both such fees, in addition to premiums.

Amended by Laws 1988, c. 227, § 9, emerg. eff. June 20, 1988.

§36-2611. Annual statement; filing; examination; summons.

A. Each such corporation shall annually, on or before the first day of March, file in the office of the Insurance Commissioner a full, true and complete statement of the condition of the corporation on the thirty-first day of December of the preceding year in such form as shall be prescribed by the Insurance Commissioner, and which shall be verified under oath by at least two of the principal officers of the corporation.

B. Whenever the Insurance Commissioner deems it pertinent or necessary, and at least once in each three (3) years, the Insurance Commissioner shall personally, or by an authorized representative, visit each corporation, and thoroughly inspect and examine its financial condition, its ability to fulfill its obligations, whether it has complied with the provisions of the law, and any other facts relative to its business methods, management and the equity of its dealings with its members. The Insurance Commissioner may summon and administer the oath to and examine as witnesses, the directors, officers, trustees, agents, representatives and members of any corporation and any other person or persons relative to its affairs, transactions and condition. Any corporation so examined shall pay the proper charges for the per diem, traveling and other necessary expenses in connection therewith.

Added by Laws 1957, p. 329, § 2611. Amended by Laws 1997, c. 418, § 92, eff. Nov. 1, 1997.

§36-2612. Nonliability of corporation.

No liability shall attach to any corporation holding a certificate of authority under this article or to the directors, officers, or employees of such corporation, by reason of the failure on the part of any of its participating hospitals, physicians, or other health care providers to render service, except as herein provided, to any of its subscribers, nor for the negligence, malpractice or other acts of its participating hospitals, physicians, or other health care providers.

Amended by Laws 1988, c. 227, § 10, emerg. eff. June 20, 1988.

§36-2613. Relationship of physician and patient.

Nothing in this article shall be deemed to alter the relationship of physician and patient. No such corporation shall in any way influence the subscriber in his free choice of hospital or physician, other than to limit its benefit to participating hospitals and physicians. Nothing in this article shall be deemed to abridge the right of any physician or hospital to decline

patients in accordance with the standards and practices of such physician or hospital, and no such corporation shall be deemed to be engaged in the corporate practice of medicine.
Laws 1957, p. 330, § 2613.

§36-2615. Repealed by Laws 1997, c. 418, § 125, eff. Nov. 1, 1997.

§36-2616. Exemptions.

The provisions of this article apply only to not-for-profit hospital service and indemnity and medical service and indemnity corporations and such corporations shall be governed by this article to the extent provided herein. Such corporations shall be exempt from all other provisions of the insurance laws of this state except that the provisions of Articles 1 (Scope of Title), 3 (Insurance Department and Insurance Commissioner), 12 (Unfair Practices and Frauds), 15 (Assets and Liabilities), 16 (Investments), 16A (Subsidiaries of Insurers), 17 (Administration of Deposits), 18 (Supervision and Conservatorship of Insurers), 19 (Rehabilitation and Liquidation) and the provisions of Sections 624 through 626 of this title and 628 through 631 of this title shall apply to such corporations to the extent that such provisions are not in conflict with the provisions of this article. No law relating to insurance hereafter enacted shall apply to such corporations unless they be expressly designated therein.

Added by Laws 1957, p. 330, § 2616, operative July 1, 1957. Amended by Laws 1988, c. 83, § 9, emerg. eff. March 25, 1988; Laws 1988, c. 227, § 11, emerg. eff. June 20, 1988; Laws 1994, c. 294, § 4, eff. Sept. 1, 1994; Laws 2006, c. 264, § 55, eff. July 1, 2006.

§36-2617. Tax exemption.

Every corporation doing business pursuant to this article is hereby declared to be a not-for-profit institution and to be exempt from state, county, district, municipal and school tax, including the taxes prescribed by this Code, and excepting only the fees prescribed by Article 3 of the Insurance Code (Insurance Department and Insurance Commissioner), the premium tax levied pursuant to Article 6 of the Insurance Code (Authorization of Insurers and General Requirements), and taxes on real and tangible personal property situate within this state.

Added by Laws 1957, p. 331, § 2617, operative July 1, 1957. Amended by Laws 1988, c. 83, § 10, emerg. eff. March 25, 1988; Laws 1988, c. 227, § 12, emerg. eff. June 20, 1988; Laws 2006, c. 264, § 56, eff. July 1, 2006.

§36-2618. Limited application.

This article shall not apply to any corporation operating or maintaining a hospital service plan or medical service plan,

participation in which is limited to its employees and the employees of other persons or corporations with which such corporation may have contracted to provide such services; provided such contract is not entered into for the purpose of evasion of the terms and spirit of this Code. As used in this section, the term "employees" shall include members of the families of employees.

Laws 1957, p. 331, § 2618.

§36-2619. Limited liability.

A. The private property of the subscribers, agents, officers, directors, members and employees of any corporation holding a certificate of authority under this article shall be wholly exempt from any of the debts, obligations, and liabilities of the corporation.

B. Until and unless the current annual statement of the corporation discloses a surplus of Fifty Thousand Dollars (\$50,000.00), such corporation shall not issue a policy or contract without a stated contingent liability of the members, which shall not be less than one time nor more than ten times the annual cash premium or dues expressed in the policy or contract.

Laws 1957, p. 331, § 2619.

§36-2620. Repealed by Laws 1997, c. 418, § 125, eff. Nov. 1, 1997.

§36-2621. Selection of licensed psychologist or licensed and certified clinical social worker - Definitions.

A. If the terms of any plan, agreement, or service contract, issued under the provisions of this article, cover services within the lawful scope of practice of a licensed psychologist, or licensed and certified clinical social worker then:

1. Such services may be performed by any person licensed to do so in this state as provided in subsection B of this section.

2. Selection of such a psychologist or social worker may be made by a subscriber under the plan, agreement or service contract and, provided other conditions are met, reimbursement shall not be denied when service is rendered by a person so licensed.

3. The provisions of this section shall apply to the plans, agreements, or service contracts which are delivered, amended, renewed, ratified, or issued for delivery in Oklahoma after October 1, 1982.

4. Any provision, exclusion, or limitation of a plan, agreement, or service contract that denies an insured the privilege of selecting such a psychologist or social worker shall, to the extent of the denial, be void, but such void provision shall not affect the validity of the other provisions of the plan, agreement, or service contract.

B. For purposes of this section:

1. "Licensed psychologist" means a person licensed and complying with the Psychologists Licensing Act, Sections 1351 through 1375 of Title 59 of the Oklahoma Statutes; and

2. "Licensed and certified clinical social worker" means a person licensed and complying with the Social Workers' Licensing Act, Sections 1250.1 (3) and 1261.1 (B) of Title 59 of the Oklahoma Statutes.

Added by Laws 1988, c. 227, § 13, emerg. eff. June 20, 1988.

§36-2622. Subsidiaries.

A corporation organized pursuant to Article 26 of the Insurance Code, either by itself or in cooperation with one or more persons, may organize or acquire one or more subsidiaries. Such subsidiaries may conduct any type of business or businesses and their authority to do so will not be limited by the fact that they are subsidiaries of such corporation. Further, such subsidiaries may conduct additional kinds of insurance as authorized by Section 2112 of Article 21 of the Insurance Code.

Added by Laws 1988, c. 227, § 13, emerg. eff. June 20, 1988.

§36-2623. Conversion to domestic mutual insurer.

A. A hospital service and medical indemnity corporation, as provided for in Article 26 of the Insurance Code, may be converted to a domestic mutual insurer as provided for in Article 21 of the Insurance Code under such plan and procedure as shall be approved by the order of the Insurance Commissioner.

B. The Commissioner shall approve any such plan or procedure if he finds:

1. That the plan would not be contrary to the interests of the subscribers or contract holders or to the public;

2. That the plan has been approved by the corporation in accordance with its articles of incorporation and bylaws;

3. Upon conversion, the corporation shall have the minimum surplus required of mutual insurers organized pursuant to Article 21 of the Insurance Code;

4. Upon completion of conversion to a mutual insurer as provided for in this section, such corporation shall be subject to and comply with all laws and regulations applicable to a mutual insurer organized pursuant to Article 21 of the Insurance Code;

5. The plan provides for definite conditions to be fulfilled by a designated early date upon which such mutualization will be deemed effective; and

6. The plan provides for the protection of all existing contractual rights of subscribers or contract holders for medical and hospital service or care or claims for reimbursement therefor, and for the mutual insurer organized pursuant to Article 21 of the

Insurance Code to assume, without reincorporation, all assets and liabilities of the corporation.

C. The corporation organized pursuant to Article 26 of the Insurance Code shall have such period of time as shall be specified in the order of the Commissioner to complete its conversion to a mutual insurer organized pursuant to Article 21 of the Insurance Code.

Added by Laws 1988, c. 227, § 14, emerg. eff. June 20, 1988.

§36-2651. Corporations authorized.

Charitable and benevolent corporations may hereafter be organized not for profit under the laws of the State of Oklahoma, for the purpose of establishing, maintaining and operating a nonprofit optometric service or indemnity plan, by complying with the provisions of this article and shall be exempt from all other provisions of the insurance laws and the general corporation laws of this state, unless otherwise specifically provided herein.

Laws 1968, c. 150, § 1, emerg. eff. April 9, 1968.

§36-2652. Application for certificate - Contents - Fee.

Such a corporation may issue contracts to its subscribers only when the Insurance Commissioner has, by certificate of authority, authorized it so to do. Application for such certificate of authority shall be made on forms supplied or approved by the Commissioner, containing such information as he shall deem necessary. Each application for such certificate of authority shall be accompanied by the fee prescribed by Section 321 of the Oklahoma Insurance Code, and copies of the following documents:

1. Articles of Incorporation signed by not less than fifty optometrists licensed to practice in Oklahoma;
2. Bylaws;
3. Proposed contracts, if any, between the applicant and participating optometrists, showing the terms under which service is to be furnished to subscribers;
4. Proposed contracts to be issued to subscribers;
5. A table of rates to be charged to subscribers;
6. Financial statement of the corporation, including the amounts of contributions paid or agreed to be paid to the corporation for working capital and the name or names of each contributor and the terms of each contribution; and
7. A statement of the area in which the corporation proposes to operate.

Added by Laws 1968, c. 150, § 2, emerg. eff. April 9, 1968.

§36-2653. Certificate of authority; requirements.

The Insurance Commissioner shall issue a certificate of authority authorizing the applicant to issue contracts to its

subscribers when it is shown to the satisfaction of the Commissioner that:

1. The applicant is established as a bona fide nonprofit optometric service or indemnity corporation;

2. The contracts between the applicant and the participating optometrists, if any, obligate each optometrist executing the same to render service to which each subscriber may be entitled under the terms of the contract to be issued to the subscribers;

3. The amounts provided as working capital of the corporation are repayable, without interest, out of operating expenses;

4. The amount of money actually available for working capital is sufficient to carry on the plan for a period of three (3) months from the date of issuance of the certificate of authority; and

5. The applicant has secured contracts of participation from sufficient optometrists to provide ample protection for its subscribers within the area proposed to be served by the applicant.

6. At least a majority of the directors of every such optometric service plan corporation must at all times be Oklahoma licensed optometrists.

Laws 1968, c. 150, § 3, emerg. eff. April 9, 1968.

§36-2654. Deposit for protection of members.

A. Corporations governed by this article shall at all times have on deposit with the Insurance Commissioner the sum of Five Thousand Dollars (\$5,000.00).

Every such corporation shall deposit with the Commissioner, not later than each February 1, an amount equal to two percent (2%) of the gross subscriptions collected during the preceding calendar year, until the deposit of such corporation reaches a total of Ten Thousand Dollars (\$10,000.00). All such deposits shall be held by the Commissioner in trust for the benefit and protection of the subscribers of the corporation making the deposit.

B. The deposit prescribed by this section shall be subject to withdrawal in whole or in part on the order of and as directed by the Commissioner, but may, with the approval of the Commissioner, be invested in bonds of the United States or of the State of Oklahoma, or any political subdivision thereof, or state warrants, which shall be assigned to the Commissioner and held by the Commissioner as provided for original deposits. The securities may, with the approval of the Commissioner, be exchanged for similar securities or cash of equal amount. Interest on securities so deposited shall be payable to the corporation depositing the same.

C. An unsettled final judgment, arising upon a certificate of participation against such a corporation, shall be a lien on the deposit prescribed by this section, subject to execution after thirty (30) days from the entry of final judgment. If the deposit is reduced thereby, it shall be replenished within ninety (90) days.

D. Upon the liquidation or dissolution of such corporation and the satisfaction of all its liabilities, any balance remaining in the deposit in the hands of the Commissioner and any other assets of the insurer shall be distributed to the holders of certificates of participation in good standing at the time proceedings for the liquidation or dissolution of the corporation were commenced, prorated according to the gross amount of subscriptions which have been paid on such certificates up to the time such proceedings were commenced.

Added by Laws 1968, c. 150, § 4, emerg. eff. April 9, 1968. Amended by Laws 2014, c. 275, § 13, eff. Nov. 1, 2014.

§36-2655. Service contracts.

Any such corporation may enter into contracts for the rendering or providing of optometric service or indemnity to any of its members with any individuals licensed in optometry in Oklahoma and who meet standards and rules of practice as set by said corporation. Any such corporation may contract with any domestic or foreign corporation or associations for the purpose of providing or rendering optometric service or indemnity. The term "optometric service plan," as used in this law, includes the contracting for the payment of fees toward, or furnishing of, professional services or ophthalmic materials authorized or permitted to be furnished by a duly licensed doctor of optometry.

Laws 1968, c. 150, § 5, emerg. eff. April 9, 1968.

§36-2656. Filing of forms and rates; disapproval.

On and after the effective date of this act, no contract providing for optometric service or indemnity shall be issued or delivered to any person in this state, nor shall any application, rider or endorsement be issued in connection therewith, until a copy of the form thereof, and the rates pertaining thereto, have been filed with and approved by the Insurance Commissioner. If the Insurance Commissioner disapproves the contract, application, rider or endorsement form, or rates, said Commissioner shall make a written decision stating the reason or reasons therefor and shall deliver a copy thereof to the corporation and it shall be unlawful for any such corporation to use any such form in this state. Any such corporation shall have twenty (20) days from date of receipt of the notice of disapproval in which to request a hearing on such disapproval.

Laws 1968, c. 150, § 6, emerg. eff. April 9, 1968.

§36-2657. Discrimination; rebates.

Discrimination between individuals of the same class in the dues or rates charged for any contract issued by any such corporation, or in the benefits payable thereon, or in any of the terms or

conditions of such contract, or in any other manner whatsoever is prohibited. This action shall not prohibit different rates, different benefits, or different underwriting procedures for individuals contracted with under different plans; provided, rates charged, benefits payable, or underwriting procedures used do not discriminate between such different plans. No such corporation, and no director, trustee, officer, agent, employee, solicitor, or other representative thereof shall pay, allow or give, or offer to pay, allow or give, directly or indirectly, as an inducement of membership, rebate of dues, payable on the contract, or any special favor or advantage in the dividends or other benefits to accrue thereon or any paid employment contract for services of any kind or any valuable consideration or inducement whatever; nor give, sell or purchase, or offer to give, sell or purchase, as an inducement of membership or in connection therewith, any stock, dividends or other securities of any other corporation, association, or partnership, or any dividends or profits to accrue thereon or anything of value whatever.

Laws 1968, c. 150, § 7, emerg. eff. April 9, 1968.

§36-2658. Membership; voting rights.

Corporations organized under this act shall be mutual corporations and every person who holds a contract with the corporation shall be a member of the corporation and shall be entitled to one or more votes based upon the number of contracts held, and such members may vote in person or by proxy.

Laws 1968, c. 150, § 8, emerg. eff. April 9, 1968.

§36-2659. Investments.

The funds of any such corporation shall be invested only in securities designated as capital funds investments by subsection A, Section 1606 of the Oklahoma Insurance Code.

Laws 1968, c. 150, § 9, emerg. eff. April 9, 1968.

§36-2660. Annual statement; filing; examinations; expenses.

A. Each such corporation shall annually, on or before the last day of February, file in the office of the Insurance Commissioner a full, true and complete statement of the condition of the corporation on the 31st day of December of the preceding year, in such form as shall be prescribed by the Insurance Commissioner, and which shall be verified under oath by at least two of the principal officers of the corporation.

B. Whenever the Insurance Commissioner deems it pertinent or necessary, and at least once in each three (3) years, the Insurance Commissioner shall personally, or by his authorized representative, visit each corporation, and thoroughly inspect and examine its financial condition, its ability to fulfill its obligations, whether

it has complied with the provisions of the law, and any other facts relative to its business methods, management and the equity of its dealings with its members. The Insurance Commissioner may summon and administer the oath to and examine as witnesses the directors, officers, trustees, agents, representatives and members of any corporation and any other person or persons relative to its affairs, transactions and condition. Any corporation so examined shall pay the proper charges for the per diem, traveling and other necessary expenses in connection therewith.

Laws 1968, c. 150, § 10, emerg. eff. April 9, 1968.

§36-2661. Nonliability of corporation.

No liability shall attach to any corporation holding a certificate of authority under this article by reason of the failure on the part of any of its participating optometrists to render service, except as herein provided, to any of its subscribers, nor for the negligence, malpractice or other acts of its participating optometrists.

Laws 1968, c. 150, § 11, emerg. eff. April 9, 1968.

§36-2662. Relationship of optometrist and patient.

Nothing in this article shall be deemed to alter the relationship of optometrist and patient. No such corporation shall in any way influence the subscriber in his free choice of optometrist, other than to limit its benefit to participating optometrists. Nothing in this article shall be deemed to abridge the right of any optometrist to decline patients in accordance with the standards and practices of such optometrist, and no such corporation shall be deemed to be engaged in the corporate practice of optometry.

Laws 1968, c. 150, § 12, emerg. eff. April 9, 1968.

§36-2663. Repealed by Laws 1997, c. 418, § 125, eff. Nov. 1, 1997.

§36-2664. Exemptions.

The provisions of this article apply only to nonprofit optometric service and indemnity corporations and such corporations shall be governed by this Article to the extent provided herein. Such corporations shall be exempt from all other provisions of the insurance laws of this state, except that the provisions of Articles 1, 3, 12, 16, 17 and 18 of the Oklahoma Insurance Code shall apply to such corporations to the extent that such provisions are not in conflict with the provisions of this article. No law relating to insurance hereafter enacted shall apply to such corporations unless they be expressly designated therein.

Laws 1968, c. 150, § 14, emerg. eff. April 9, 1968.

§36-2665. Tax exemption.

Every corporation doing business pursuant to this article is hereby declared to be a nonprofit and benevolent institution and to be exempt from state, county, district, municipal and school tax, including the taxes prescribed by the Oklahoma Insurance Code, and excepting only the fees prescribed by Section 321 of the Oklahoma Insurance Code, and taxes on real and tangible personal property situate within this state.

Laws 1968, c. 150, § 15, emerg. eff. April 9, 1968.

§36-2666. Limited liability.

A. The private property of the subscribers, agents, officers, directors, members and employees of any corporation holding a certificate of authority as provided by Section 2651 et seq. of this title shall be exempt from any of the debts, obligations and liabilities of the corporation.

B. Unless the current annual statement of the corporation discloses a surplus of Fifty Thousand Dollars (\$50,000.00), such corporation shall not contract for providing optometric service or indemnity without a stated contingent liability of the participating optometrists licensed in optometry in Oklahoma and who meet the standards and rules of practice of the corporation, which shall not be less than one time nor more than ten times the annual cash premium or dues expressed in the policy or contract.

Laws 1968, c. 150, § 16, emerg. eff. April 9, 1968; Laws 1979, c. 134, § 1, emerg. eff. May 3, 1979.

§36-2667. Conflicting laws.

Nothing in this Act shall be construed to supersede the provisions of Title 59, Oklahoma Statutes 1961, Sections 581 through 592, inclusive, 601 through 606, inclusive, and 941 through 947, inclusive, or as the same may be hereafter amended. In the event of the conflict of any of the provisions of this act with any of the above-cited sections then such cited section shall take precedence over this act and this act shall be construed accordingly.

Laws 1968, c. 150, § 17, emerg. eff. April 9, 1968.

§36-2671. Corporations authorized.

Nonprofit charitable and benevolent corporations may hereafter be organized under the laws of the State of Oklahoma for the purpose of establishing, maintaining and operating a nonprofit dental service plan by complying with the provisions of this Article, and shall be exempt from all other provisions of the insurance laws and the general corporation laws of this state, except where such other laws are specifically made applicable by the provisions of this Article.

Laws 1973, c. 104, § 1, emerg. eff. May 3, 1973.

§36-2672. Application for certificate - Contents - Fee.

A dental service corporation may issue contracts to its subscribers only when the Insurance Commissioner has, by certificate of authority, authorized it to do so. Application for such certificate of authority shall be made on forms supplied or approved by the Commissioner, containing such information as he shall deem necessary. Each application for such certificate of authority shall be accompanied by the fee prescribed by Article 3 of Title 36, Oklahoma Statutes, and copies of the following documents:

1. Articles of Incorporation;
2. Bylaws;
3. Proposed contracts to be issued to subscribers;
4. Financial statement of the corporation, including the amounts of contributions paid; and
5. A statement of the area in which the corporation proposes to operate.

Added by Laws 1973, c. 104, § 2, emerg. eff. May 3, 1973.

§36-2673. Certificate of authority - Requirements.

The Insurance Commissioner shall certify nonprofit dental service corporations by issuing a certificate of authority, authorizing the applicant to issue contracts to its subscribers, when it is shown to the satisfaction of the Commissioner that:

1. The applicant is established as a bona fide nonprofit dental service corporation;
2. The contracts between the applicant and the participating dentists or other providers of health services, if any, obligate each provider executing the same to render service to which each subscriber may be entitled under the terms of the contract to be issued to the subscribers;
3. The amount of required working capital of the corporation is paid into the corporation and, if subject to repayment, can be repaid, but without interest, and only out of operating income;
4. The amount of money actually available for working capital is sufficient to carry on the plan for a period of three (3) months from the date of issuance of the certificate of authority; and
5. The applicant has secured signed contracts of participation from not less than one-third (1/3) of the dentists within this state who hold a current license issued by the Board of Dentistry pursuant to the State Dental Act. The form of such contracts of participation shall be approved by the Board of Dentistry prior to securing the required signatures.

Added by Laws 1973, c. 104, § 3, emerg. eff. May 3, 1973. Amended by Laws 2000, c. 283, § 1, eff. Nov. 1, 2000.

§36-2674. Deposit for protection of subscribers.

A. Each corporation governed by this Article shall at all times have on deposit with the Insurance Commissioner the sum of Fifteen Thousand Dollars (\$15,000.00). In addition every such corporation shall deposit with the Commissioner, not later than each February 1, an amount equal to two percent (2%) of the gross subscriptions collected during the preceding calendar year, until the deposit of such corporation reaches a total of Twenty-five Thousand Dollars (\$25,000.00). All such deposits shall be held by the Commissioner in trust for the benefit and protection of the subscribers of the corporation making the deposit.

B. The deposit prescribed by this section shall be subject to withdrawal in whole or in part on the order of and as directed by the Commissioner and may be invested in bonds of the United States or of the State of Oklahoma, or any political subdivision thereof, or state warrants, which shall be assigned to the Commissioner and held by the Commissioner as provided for original deposits. The securities may, with the approval of the Commissioner, be exchanged for similar securities or cash of equal amount. Interest on securities so deposited shall be payable to the corporation depositing the same.

C. An unsettled final judgment, arising upon a certificate of participation against such a corporation, shall be a lien on the deposit prescribed by this section, subject to execution after thirty (30) days from the entry of final judgment. If the deposit is reduced thereby, it shall be replenished within ninety (90) days.

D. Upon the liquidation or dissolution of such corporation and the satisfaction of all its liabilities, any balance remaining in the deposit in the hands of the Commissioner and any other assets of the insurer shall be distributed in the manner directed by the directors of the dental service corporation.

Added by Laws 1973, c. 104, § 4, emerg. eff. May 3, 1973. Amended by Laws 2014, c. 275, § 14, eff. Nov. 1, 2014.

§36-2675. Contracts; investments; law applicable.

A. A certified corporation, in addition to contracting with the licensed dentists of the state, may contract for its subscribers the use of hospital facilities located in the state.

B. A certified corporation may contract with any other person who is licensed and qualified for the purpose of providing dental services to or for the subscribers but no certified corporation shall enter into an exclusive or preferential contract with any person.

C. A certified corporation may contract with any other person for the cooperative administration or underwriting with regard to the performance of the obligations created upon it under the contracts it issues to the subscribers and to participating dentists.

D. A certified corporation may join with, contract with or become a member of any organization of other dental service or indemnity corporations, nonprofit hospital or hospital service corporations or medical service or indemnity corporations, either domestic or foreign, to create, establish or maintain an agency, group or entity to facilitate the providing of dental services for subscribers located within or outside the State of Oklahoma.

E. A certified corporation may join with, contract with or serve in any capacity with any agency of the United States of America, the State of Oklahoma or any county, city or town, in connection with any program or undertaking sponsored by one or more of the above.

F. A certified corporation may invest in such real and personal property as is reasonably necessary to conduct its business. No law relating to insurance hereafter enacted shall apply to dental service corporations unless expressly designated therein as applicable.

Laws 1973, c. 104, § 5, emerg. eff. May 3, 1973.

§36-2676. Filing of forms and rates; disapproval.

On and after the effective date of this act, no contract providing for dental service or indemnity shall be issued or delivered to any person in this state, nor shall any application, rider or endorsement be issued in connection therewith, until a copy of the form thereof and the rates pertaining thereto have been filed with and approved by the Insurance Commissioner. If the Insurance Commissioner disapproves the contract, application, rider or endorsement form, or rates, he shall make a written decision stating the reason or reasons therefor and shall deliver a copy thereof to the corporation and it shall be unlawful for any such corporation to use any such form in this state. Any such corporation shall have thirty (30) days from date of receipt of the notice of disapproval in which to request a hearing on such disapproval.

Laws 1973, c. 104, § 6, emerg. eff. May 3, 1973.

§36-2677. Inducements prohibited.

No dental service corporation, and no director, trustee, officer, agent, employee, solicitor or other representative thereof shall pay, allow or give, or offer to pay, allow or give, directly or indirectly, as an inducement of membership, any rebate of premiums or dues, payable on the policy or contract, or any special favor or advantage in the dividends or other benefits to accrue thereon, or any paid employment contract for services of any kind or any value, consideration or inducement whatever; nor give, sell or purchase, or offer to give, sell or purchase, as an inducement of membership or in connection therewith, any stock, dividends or other securities of any insurance company or other corporation,

association or partnership, or any dividends or profits to accrue thereon or anything of value whatever.

Laws 1973, c. 104, § 7, emerg. eff. May 3, 1973.

§36-2678. Directors.

The directors of a dental service corporation shall at all times include representatives of:

1. Dentists licensed to practice in this state; and
2. The general public.

Laws 1973, c. 104, § 8, emerg. eff. May 3, 1973.

§36-2679. Participating dentists as members; meetings; officers.

Every participating dentist under contract with a dental service corporation created under this Article shall be a member of such corporation. Annually the members in person or by proxy shall meet to conduct the business of the corporation. At each such annual meeting, or at any special meeting properly called as provided for in the bylaws of the corporation, each person who is a member shall have one vote and may exercise the privilege of voting on all matters brought before the membership. A simple majority of the votes cast shall be sufficient to carry all matters brought before the membership. If a majority of the directors at any time so decides, a matter may be submitted to a special meeting of the members of the corporation following such procedure as the corporation may provide for in its bylaws. At each annual meeting, the members shall vote to elect one-third (1/3) of the directors of the corporation. The directors shall be elected for terms of three (3) years in office. The directors shall elect the officers, who shall serve for one (1) year in office and thereafter until their successors are designated by the directors.

Laws 1973, c. 104, § 9, emerg. eff. May 3, 1973.

§36-2680. Annual statement - Examinations - Expenses.

A. Each dental service corporation shall annually, on or before the last day of March, file in the office of the Insurance Commissioner a full, true and complete statement of the condition of the corporation on December 31 of the preceding year in such form as shall be prescribed by the Commissioner, and which shall be verified under oath by at least two of the principal officers of the corporation.

B. Whenever the Insurance Commissioner deems it pertinent or necessary, and at least once in each period of five (5) years, the Commissioner shall personally, or by authorized representative, visit each corporation and thoroughly inspect and examine its financial condition, its ability to fulfill its obligations, whether it has complied with the provisions of the law, and any other facts relative to its business methods, management and the equity of its

dealings with its members. The Commissioner may summon and administer the oath to and examine as witnesses the directors, officers, trustees, agents, representatives and members of any corporation and any other person or persons relative to its affairs, transactions and condition. Any corporation so examined shall pay the proper charges for the per diem, travel and other necessary expenses in connection therewith.

Added by Laws 1973, c. 104, § 10, emerg. eff. May 3, 1973. Amended by Laws 2014, c. 275, § 15, eff. Nov. 1, 2014.

§36-2681. Nonliability.

A dental service corporation shall not be liable for injuries resulting from negligence or malpractice on the part of any participating or other dentist or supplier of services to any subscriber. A participating dentist shall not be liable for any wrongful or negligent conduct by a dental service corporation or any of its officers, directors or agents.

Laws 1973, c. 104, § 11, emerg. eff. May 3, 1973.

§36-2682. Relationship of dentist and patient.

Nothing in this Article shall be deemed to alter the statutory relationship of dentist and patient which has heretofore been established. No dental service corporation shall in any way attempt to influence the subscriber in the free choice of a dentist other than to limit its benefit to properly licensed dentists of this state who are in good standing with the Board of Dentistry. Nothing in this Article shall be deemed to abridge the right of any dentist to decline patients in accordance with the standards of practices of such dentist; and no such corporation shall be deemed to be engaged in the corporate practice of dentistry.

Added by Laws 1973, c. 104, § 12, emerg. eff. May 3, 1973. Amended by Laws 2000, c. 283, § 2, eff. Nov. 1, 2000.

§36-2683. Repealed by Laws 1997, c. 418, § 125, eff. Nov. 1, 1997.

§36-2684. Exemptions.

The provisions of this Article shall govern and apply only to nonprofit dental service corporations. Such corporations shall be exempt from all other provisions of the insurance laws of this state; provided, however, that Articles 1, 3, 12, 17, 18, and Section 1606 of Title 36, Oklahoma Statutes, shall apply to such corporations to the extent that such provisions are not in conflict with the provisions of this Article.

Laws 1973, c. 104, § 14, emerg. eff. May 3, 1973.

§36-2685. Tax exemption.

Every corporation doing business pursuant to this Article is hereby declared to be a nonprofit, charitable and benevolent institution and to be exempt from state, county, district, municipal and school taxes, including the taxes prescribed by the Oklahoma Insurance Code, excepting only the fees prescribed by Section 321 of Title 36, Oklahoma Statutes, and taxes on real and tangible personal property situated within this state.
Laws 1973, c. 104, § 15, emerg. eff. May 3, 1973.

§36-2686. Limited liability.

The private property of the subscribers, agents, officers, directors, members and employees of any corporation holding a certificate of authority under this Article shall be wholly exempt from any of the debts, obligations and liabilities of the corporation.
Laws 1973, c. 104, § 16, emerg. eff. May 3, 1973.

§36-2687. Conflicting laws.

Nothing in this Article shall be construed to supersede the provisions of Sections 328.1 through 328.52 of Title 59, Oklahoma Statutes, or as the same may be hereafter amended. In the event of the conflict of any of the provisions of this Article with any of the above-cited sections, then such cited section shall take precedence over this Article, and this Article shall be construed accordingly.
Laws 1973, c. 104, § 17, emerg. eff. May 3, 1973.

§36-2691.1. Corporations authorized.

Nonprofit charitable and benevolent corporations may hereafter be organized under the laws of the State of Oklahoma for the purpose of establishing, maintaining and operating a nonprofit chiropractic service plan by complying with the provisions of this article, and shall be exempt from all other provisions of the insurance laws and the general corporation laws of this state, except where such other laws are specifically made applicable by the provisions of this article.
Laws 1979, c. 71, § 1.

§36-2691.2. Application for certificate; contents; fee.

A chiropractic service corporation may issue contracts to its subscribers only when the Insurance Commissioner has, by certificate of authority, authorized it to do so. Application for such certificate of authority shall be made on forms supplied or approved by the Commissioner, containing such information as he shall deem necessary. Each application for such certificate of authority shall be accompanied by the fee prescribed by Article 3 of Title 36 of the Oklahoma Statutes, and copies of the following documents:

1. Articles of Incorporation;
 2. Bylaws;
 3. Proposed contracts to be issued to subscribers;
 4. Financial statement of the corporation, including the amounts of contributions paid; and
 5. A statement of the area in which the corporation proposes to operate.
- Laws 1979, c. 71, § 2.

§36-2691.3. Certificate of authority; requirement.

The Insurance Commissioner shall certify such corporation by issuing a certificate of authority, authorizing the applicant to issue contracts to its subscribers, when it is shown to the satisfaction of the Commissioner that:

1. The applicant is established as a bona fide nonprofit chiropractic service corporation;
2. The contracts between the applicant and the participating chiropractors or other providers of health services, if any, obligate each provider executing the same to render service to which each subscriber may be entitled under the terms of the contract to be issued to the subscribers;
3. The amount of required working capital, of the corporation is paid into the corporation and, if subject to repayment, can be repaid, but without interest, and only out of operating income;
4. The amount of money actually available for working capital is sufficient to carry on the plan for a period of three (3) months from the date of issuance of the certificate of authority; and
5. The applicant has secured signed contracts of participation from not less than one-third of the chiropractors within the State of Oklahoma, who are licensed by the State of Oklahoma. The form of such contracts of participation shall be approved by the Board of Chiropractic Examiners of Oklahoma prior to securing the required signatures.

Laws 1979, c. 71, § 3.

§36-2691.4. Deposit for protection of subscribers.

A. Each corporation governed by this article shall at all times have on deposit with the Insurance Commissioner the sum of Fifteen Thousand Dollars (\$15,000.00). In addition every such corporation shall deposit with the Commissioner, not later than each February 1, an amount equal to two percent (2%) of the gross subscriptions collected during the preceding calendar year, until the deposit of such corporation reaches a total of Twenty-five Thousand Dollars (\$25,000.00). All such deposits shall be held by the Commissioner in trust for the benefit and protection of the subscribers of the corporation making the deposit.

B. The deposit prescribed by this section shall be subject to withdrawal in whole or in part on the order of and as directed by the Commissioner and may be invested in bonds of the United States or of the State of Oklahoma, or any political subdivision thereof, or state warrants, which shall be assigned to the Commissioner and held by the Commissioner as provided for original deposits. The securities may, with the approval of the Commissioner, be exchanged for similar securities or cash of equal amount. Interest on securities so deposited shall be payable to the corporation depositing the same.

C. An unsettled final judgment, arising upon a certificate of participation against such a corporation, shall be a lien on the deposit prescribed by this section, subject to execution after thirty (30) days from the entry of final judgment. If the deposit is reduced thereby, it shall be replenished within ninety (90) days.

D. Upon the liquidation or dissolution of such corporation and the satisfaction of all its liabilities, any balance remaining in the deposit in the hands of the Commissioner and any other assets of the insurer shall be distributed in the manner directed by the directors of the chiropractic service corporation.

Added by Laws 1979, c. 71, § 4, eff. Oct. 1, 1979. Amended by Laws 2014, c. 275, § 16, eff. Nov. 1, 2014.

§36-2691.5. Contracts; investments.

A. A certified corporation may contract with any other person who is licensed and qualified for the purpose of providing chiropractic services to or for the subscribers but no certified corporation shall enter into an exclusive or preferential contract with any person.

B. A certified corporation may contract with any other person for the cooperative administration or underwriting with regard to the performance of the obligations created upon it under the contracts it issues to the subscribers and to participating chiropractors.

C. A certified corporation may join with, contract with or become a member of any organization of other chiropractic service or indemnity corporations, to create, establish or maintain an agency, group or entity to facilitate the providing of chiropractic services for subscribers located within or outside the State of Oklahoma.

D. A certified corporation may join with, contract with or serve in any capacity with any agency of the United States of America, the State of Oklahoma or any county, city or town, in connection with any program or undertaking sponsored by one or more of the above.

E. A certified corporation may invest in such real and personal property as is reasonably necessary to conduct its business. The prudent-man test shall be applicable to all such investments.

Laws 1979, c. 71, § 5.

§36-2691.6. Filing of forms and rates; disapproval.

On and after the effective date of this act, no contract providing for chiropractic service or indemnity shall be issued or delivered to any person in this state, nor shall any application, rider or endorsement be issued in connection therewith, until a copy of the form thereof and the rates pertaining thereto have been filed with and approved by the Insurance Commissioner. If the Insurance Commissioner disapproves the contract, application, rider or endorsement form, or rates, he shall make a written decision stating the reason or reasons therefor and shall deliver a copy thereof to the corporation and it shall be unlawful for any such corporation to use any such form in this state. Any such corporation shall have thirty (30) days from date of receipt of the notice of disapproval in which to request a hearing on such disapproval.

Laws 1979, c. 71, § 6.

§36-2691.7. Inducements prohibited.

No chiropractic service corporation, and no director, trustee, officer, agent, employee, solicitor or other representative thereof shall pay, allow or give, or offer to pay, allow or give, directly or indirectly, as an inducement of membership, any rebate of premiums or dues, payable on the policy or contract, or any special favor or advantage in the dividends or other benefits to accrue thereon, or any paid employment contract for services of any kind or any value, consideration or inducement whatever; nor give, sell or purchase, or offer to give, sell or purchase, as an inducement of membership or in connection therewith, any stock, dividends or other securities of any insurance company or other corporation, association or partnership, or any dividends or profits to accrue thereon or anything of value whatever.

Laws 1979, c. 71, § 7.

§36-2691.8. Directors.

The directors of a chiropractic service corporation shall at all times include representatives of:

1. Chiropractors licensed to practice in this state; and
2. The general public.

Laws 1979, c. 71, § 8.

§36-2691.9. Practicing chiropractors as members, meetings; voting; officers.

Every participating chiropractor under contract with a chiropractic service corporation created under this article shall be a member of such corporation. Annually the members in person or by proxy shall meet to conduct the business of the corporation. At

each such annual meeting, or at any special meeting properly called as provided for in the bylaws of the corporation, each person who is a member shall have one vote and may exercise the privilege of voting on all matters brought before the membership. A simple majority of the votes cast shall be sufficient to carry all matters brought before the membership. If a majority of the directors at any time so decides, a matter may be submitted to a special meeting of the members of the corporation following such procedure as the corporation may provide for in its bylaws. At each annual meeting, the members shall vote to elect one-third of the directors of the corporation. The directors shall be elected for terms of three (3) years in office. The directors shall elect the officers, who shall serve for one (1) year in office and thereafter until their successors are designated by the directors.
Laws 1979, c. 71, § 9.

§36-2691.10. Annual statement; examinations; expenses.

A. Each chiropractic service corporation shall annually, on or before the last day of March, file in the office of the Insurance Commissioner a full, true and complete statement of the condition of the corporation on December 31 of the preceding year in such form as shall be prescribed by the Insurance Commissioner, and which shall be verified under oath by at least two (2) of the principal officers of the corporation.

B. Whenever the Insurance Commissioner deems it pertinent or necessary, and at least once in each period of three (3) years, the Insurance Commissioner shall personally, or by his authorized representative, visit each corporation and thoroughly inspect and examine its financial condition, its ability to fulfill its obligations, whether it has complied with the provisions of the law, and any other facts relative to its business methods, management and the equity of its dealings with its members. The Insurance Commissioner may summon and administer the oath to and examine as witnesses the directors, officers, trustees, agents, representatives and members of any corporation and any other person or persons relative to its affairs, transactions and condition. Any corporation so examined shall pay the proper charges for the per diem, travel and other necessary expenses in connection therewith.
Laws 1979, c. 71, § 10.

§36-2691.11. Nonliability.

A chiropractic service corporation shall not be liable for injuries resulting from negligence or malpractice on the part of any participating or other chiropractor or supplier of services to any subscriber. A participating chiropractor shall not be liable for any wrongful or negligent conduct by a chiropractic service corporation or any of its officers, directors or agents.

Laws 1979, c. 71, § 11.

§36-2691.12. Relationship of chiropractor and patient.

Nothing in this article shall be deemed to alter the statutory relationship of chiropractor and patient which has heretofore been established. No chiropractic service corporation shall in any way attempt to influence the subscriber in his free choice of a chiropractor other than to limit its benefit to properly licensed chiropractors of the State of Oklahoma who are in good standing with the Board of Chiropractic Examiners of Oklahoma. Nothing in this article shall be deemed to abridge the right of any chiropractor to decline patients in accordance with the standards of practices of such chiropractor; and no such corporation shall be deemed to be engaged in the corporate practice of chiropractic.

Laws 1979, c. 71, § 12.

§36-2691.13. Repealed by Laws 1997, c. 418, § 125, eff. Nov. 1, 1997.

§36-2691.14. Exemptions.

The provisions of this article shall govern and apply only to nonprofit chiropractic service corporations. Such corporations shall be exempt from all other provisions of the insurance laws of this state. Provided, that Articles 1, 3, 12, 17, 18, and Section 1606 of Title 36 of the Oklahoma Statutes, shall apply to such corporations to the extent that such provisions are not in conflict with the provisions of this article.

Laws 1979, c. 71, § 14.

§36-2691.15. Tax exemption.

Every corporation doing business pursuant to this article is hereby declared to be a nonprofit, charitable and benevolent institution and to be exempt from state, county, district, municipal and school taxes, including the taxes prescribed by the Oklahoma Insurance Code, excepting only the fees prescribed by Section 321 of Title 36 of the Oklahoma Statutes, and taxes on real and tangible personal property situated within this state.

Laws 1979, c. 71, § 15.

§36-2691.16. Limited liability.

The private property of the subscribers, agents, officers, directors, members and employees of any corporation holding a certificate of authority under this article shall be wholly exempt from any of the debts, obligations and liabilities of the corporation.

Laws 1979, c. 71, § 16.

§36-2691.17. Conflicting laws.

Nothing in this article shall be construed to supersede the provisions of Sections 161 through 168 of Title 59 of the Oklahoma Statutes. In the event of the conflict of any of the provisions of this article with any of the above-cited sections, then such cited section shall take precedence over this article, and this article shall be construed accordingly.

Laws 1979, c. 71, § 17.

§36-2701. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2701.1. Fraternal benefit society defined.

Any incorporated society, order or supreme lodge, without capital stock, including one exempted under paragraph 2 of subsection A of Section 38 of this act, whether incorporated or not, conducted solely for the benefit of its members and their beneficiaries and not for profit, operated on a lodge system with ritualistic form of work, having a representative form of government, and which provides benefits in accordance with this act, is hereby declared to be a fraternal benefit society.

Added by Laws 1992, c. 76, § 1, eff. Jan. 1, 1993.

§36-2702. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2702.1. Lodge system defined.

A. A society is operating on the lodge system if it has a supreme governing body and subordinate lodges into which members are elected, initiated or admitted in accordance with its laws, rules and ritual. Subordinate lodges shall be required by the laws of the society to hold regular meetings at least once in each month in furtherance of the purposes of the society.

B. A society may, at its option, organize and operate lodges for children under the minimum age for adult membership. Membership and initiation in local lodges shall not be required of such children, nor shall they have a voice or vote in the management of the society.

Added by Laws 1992, c. 76, § 2, eff. Jan. 1, 1993.

§36-2703. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2703.1. Representative form of government defined.

A society has a representative form of government when:

1. It has a supreme governing body constituted in one of the following ways:

- a. Assembly. The supreme governing body is an assembly composed of delegates elected directly by the members or at intermediate assemblies or conventions of

members or their representatives, together with other delegates as may be prescribed in the society's laws. A society may provide for election of delegates by mail. The elected delegates shall constitute a majority in number and shall not have less than two-thirds (2/3) of the votes and not less than the number of votes required to amend the society's laws. The assembly shall be elected and shall meet at least once every four (4) years and shall elect a board of directors to conduct the business of the society between meetings of the assembly. Vacancies on the board of directors between elections may be filled in the manner prescribed by the society's laws, or

- b. Direct Election. The supreme governing body is a board composed of persons elected by the members, either directly or by their representatives in intermediate assemblies, and any other persons prescribed in the society's laws. A society may provide for election of the board by mail. Each term of a board member may not exceed four (4) years. Vacancies on the board between elections may be filled in the manner prescribed by the society's laws. Those persons elected to the board shall constitute a majority in number and not less than the number of votes required to amend the society's laws. A person filling the unexpired term of an elected board member shall be considered to be an elected member. The board shall meet at least quarterly to conduct the business of the society;

2. The officers of the society are elected either by the supreme governing body or by the board of directors;

3. Only benefit members are eligible for election to the supreme governing body, the board of directors or any intermediate assembly; and

4. Each voting member has one vote; no vote may be cast by proxy.

Added by Laws 1992, c. 76, § 3, eff. Jan. 1, 1993.

§36-2704. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2704.1. Definitions.

As used in this article:

1. "Benefit contract" means the agreement for provision of benefits authorized by Section 16 of this act, as that agreement is described in subsection A of Section 19 of this act;

2. "Benefit member" means an adult member who is designated by the laws or rules of the society to be a benefit member under a benefit contract;

3. "Certificate" means the document issued as written evidence of the benefit contract;

4. "Laws" means the society's articles of incorporation, constitution and bylaws, however designated;

5. "Lodge" means subordinate member units of the society, known as camps, courts, councils, branches or by any other designation;

6. "Premiums" means premiums, rates, dues or other required contributions by whatever name known, which are payable under the certificate;

7. "Rules" means all rules, regulations or resolutions adopted by the supreme governing body or board of directors which are intended to have general application to the members of the society; and

8. "Society" means fraternal benefit society, unless otherwise indicated.

Added by Laws 1992, c. 76, § 4, eff. Jan. 1, 1993.

§36-2705. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2705.1. Purposes - powers.

A. A society shall operate for the benefit of members and their beneficiaries by:

1. Providing benefits as specified in Section 16 of this act; and

2. Operating for one or more social, intellectual, educational, charitable, benevolent, moral, fraternal, patriotic or religious purposes for the benefit of its members, which may also be extended to others.

Such purposes may be carried out directly by the society or indirectly through subsidiary corporations or affiliated organizations.

B. Every society shall have the power to adopt laws and rules for the government of the society, the admission of its members, and the management of its affairs. It shall have the power to change, alter, add to or amend such laws and rules and shall have such other powers as are necessary and incidental to carrying into effect the objects and purposes of the society.

Added by Laws 1992, c. 76, § 5, eff. Jan. 1, 1993.

§36-2706. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2706.1. Laws or rules required.

A. A society shall specify in its laws or rules:

1. Eligibility standards for each and every class of membership; provided, if benefits are provided on the lives of children, the minimum age for adult membership shall be set at not less than age fifteen (15) nor greater than age twenty-one (21);

2. The process for admission to membership for each membership class; and

3. The rights and privileges of each membership class; provided, only benefit members shall have the right to vote on the management of the insurance affairs of the society.

B. A society may also admit social members who shall have no voice or vote in the management of the insurance affairs of the society.

C. Membership rights in the society are personal to the member and are not assignable.

Added by Laws 1992, c. 76, § 6, eff. Jan. 1, 1993.

§36-2707. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2707.1. Principal office - Annual statement - Grievance and complaint procedures.

A. The principal office of any domestic society shall be located in this state. The meetings of its supreme governing body may be held in any state, district, province or territory wherein such society has at least one subordinate lodge. All business transacted at such meetings shall be as valid in all respects as if such meetings were held in this state. The minutes of the proceedings of the supreme governing body and of the board of directors shall be in the English language.

B. 1. A society may provide in its laws for an official publication in which any notice, report, or statement required by law to be given to members, including notice of election, may be published. Such required reports, notices and statements shall be printed conspicuously in the publication. If the records of a society show that two or more members have the same mailing address, an official publication mailed to one member is deemed to be mailed to all members at the same address unless a member requests a separate copy.

2. Not later than June 1 of each year, a synopsis of the society's annual statement providing an explanation of the facts concerning the condition of the society thereby disclosed shall be printed and mailed to each benefit member of the society or, in lieu thereof, such synopsis may be published in the society's official publication.

C. A society may provide in its laws or rules for grievance or complaint procedures for members.

Added by Laws 1992, c. 76, § 7, eff. Jan. 1, 1993.

§36-2708. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2708.1. No personal liability - Indemnification and reimbursement - Insurance.

A. The officers and members of the supreme governing body or any subordinate body of a society shall not be personally liable for any benefits provided by a society.

B. Any person may be indemnified and reimbursed by any society for expenses reasonably incurred by, and liabilities imposed upon, such person in connection with or arising out of any action, suit or proceeding, whether civil, criminal, administrative or investigative, or threat thereof, in which the person may be involved by reason of the fact that he or she is or was a director, officer, employee or agent of the society or of any firm, corporation or organization which he or she served in any capacity at the request of the society. A person shall not be so indemnified or reimbursed:

1. In relation to any matter in such action, suit or proceeding as to which he or she shall finally be adjudged to be or have been guilty of breach of a duty as a director, officer, employee or agent of the society; or

2. In relation to any matter in such action, suit or proceeding, or threat thereof, which has been made the subject of a compromise settlement, unless in either such case the person acted in good faith for a purpose the person reasonably believed to be in or not opposed to the best interests of the society and, in a criminal action or proceeding, in addition, had no reasonable cause to believe that his or her conduct was unlawful. The determination whether the conduct of such person met the standard required in order to justify indemnification and reimbursement in relation to any matter described in paragraph 1 or 2 of this subsection may only be made by the supreme governing body or board of directors by a majority vote of a quorum consisting of persons who were not parties to such action, suit or proceeding or by a court of competent jurisdiction. The termination of any action, suit or proceeding by judgment, order, settlement, conviction, or upon a plea of no contest, as to such person shall not in itself create a conclusive presumption that the person did not meet the standard of conduct required in order to justify indemnification and reimbursement. The foregoing right of indemnification and reimbursement shall not be exclusive of other rights to which such person may be entitled as a matter of law and shall inure to the benefit of his or her heirs, executors and administrators.

C. A society shall have power to purchase and maintain insurance on behalf of any person who is or was a director, officer, employee or agent of the society, or who is or was serving at the

request of the society as a director, officer, employee or agent of any other firm, corporation, or organization against any liability asserted against such person and incurred by him or her in any such capacity or arising out of his or her status as such, whether or not the society would have the power to indemnify the person against such liability under this section.

Added by Laws 1992, c. 76, § 8, eff. Jan. 1, 1993.

§36-2709. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2709.1. Waiver.

The laws of the society may provide that no subordinate body, nor any of its subordinate officers or members, shall have the power or authority to waive any of the provisions of the laws of the society. Such provision shall be binding on the society and every member and beneficiary of a member.

Added by Laws 1992, c. 76, § 9, eff. Jan. 1, 1993.

§36-2710. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2710.1. Organization - Corporate powers retained.

A. A domestic society organized on or after the effective date of this act shall only be formed by ten or more citizens of the United States, a majority of whom are citizens of this state, who desire to form a fraternal benefit society and who may make, sign and acknowledge before some officer competent to take acknowledgment of deeds, articles of incorporation, in which shall be stated:

1. The proposed corporate name of the society, which shall not so closely resemble the name of any society or insurance company as to be misleading or confusing;

2. The purposes for which it is being formed and the mode in which its corporate powers are to be exercised. Such purposes shall not include more liberal powers than are granted by this article; and

3. The names and residences of the incorporators and the names, residences and official titles of all the officers, trustees, directors, or other persons who are to have and exercise the general control of the management of the affairs and funds of the society for the first year or until the ensuing election at which all such officers shall be elected by the supreme governing body, which election shall be held not later than one (1) year from the date of issuance of the permanent certificate of authority.

B. Such articles of incorporation, duly certified copies of the society's bylaws and rules, copies of all proposed forms of certificates, applications therefor, and circulars to be issued by the society, evidence of surplus funds as required herein and a bond conditioned upon the return to applicants of the advanced payments

if the organization is not completed within one (1) year shall be filed with the Insurance Commissioner, who may require such further information as the Commissioner deems necessary. The bond with sureties approved by the Commissioner shall be in such amount, not less than Three Hundred Thousand Dollars (\$300,000.00) nor more than One Million Five Hundred Thousand Dollars (\$1,500,000.00), as required by the Commissioner. All documents filed are to be in the English language. If the purposes of the society conform to the requirements of this article and all provisions of the law have been complied with, the Commissioner shall so certify, retain and file the articles of incorporation and furnish the incorporators a preliminary certificate of authority authorizing the society to solicit members as hereinafter provided. No solicitation of or enrollment of applicants shall be commenced until there has been submitted to the Insurance Commissioner evidence that such fraternal benefit society has surplus funds in an amount equal to that required of a domestic mutual life insurer.

C. No preliminary certificate of authority granted under the provisions of this section shall be valid after one (1) year from its date or after such further period, not exceeding one (1) year, as may be authorized by the Commissioner upon cause shown, unless the five hundred applicants hereinafter required have been secured and the organization has been completed as herein provided. The articles of incorporation and all other proceedings thereunder shall become null and void in one (1) year from the date of the preliminary certificate of authority, or at the expiration of the extended period, unless the society shall have completed its organization and received a certificate of authority to do business as hereinafter provided.

D. Upon receipt of a preliminary certificate of authority from the Commissioner, the society may solicit members for the purpose of completing its organization, shall collect from each applicant the amount of not less than one regular monthly premium in accordance with its table of rates, and shall issue to each such applicant a receipt for the amount collected. No society shall incur any liability other than for the return of the advance premium, nor issue any certificate, nor pay, allow, or offer or promise to pay or allow, any benefit to any person until:

1. Actual bona fide applications for benefits have been secured on not less than five hundred applicants, and any necessary evidence of insurability has been furnished to and approved by the society;

2. At least ten subordinate lodges have been established into which the five hundred applicants have been admitted;

3. There has been submitted to the Commissioner, under oath of the president or secretary, or corresponding officer of the society, a list of such applicants, giving their names, addresses, date each was admitted, name and number of the subordinate lodge of which each

applicant is a member, amount of benefits to be granted and premiums therefor; and

4. It shall have been shown to the Commissioner, by sworn statement of the treasurer, or corresponding officer of such society, that at least five hundred applicants have each paid in cash at least one regular monthly premium as herein provided, which premiums in the aggregate shall amount to at least One Hundred Fifty Thousand Dollars (\$150,000.00). Said advance premiums shall be held in trust during the period of organization and if the society has not qualified for a certificate of authority within one (1) year, as herein provided, such premiums shall be returned to the applicants.

E. The Commissioner may make such examination and require such further information as the Commissioner deems advisable. Upon representation of satisfactory evidence that the society has complied with all the provisions of law, the Commissioner shall issue to the society a certificate of authority to that effect and that the society is authorized to transact business pursuant to the provisions of this act. The certificate of authority shall be prima facie evidence of the existence of the society at the date of the certificate. The Commissioner shall cause a record of the certificate of authority to be made. A certified copy of the record may be given in evidence with like effect as the original certificate of authority.

F. Any incorporated society authorized to transact business in this state at the time this act becomes effective shall not be required to reincorporate.

Added by Laws 1992, c. 76, § 10, eff. Jan. 1, 1993.

§36-2711. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2711.1. Articles of incorporation, constitution and laws - Amendments.

A. A domestic society may amend its laws in accordance with the provisions thereof by action of its supreme governing body at any regular or special meeting thereof or, if its laws so provide, by referendum. The referendum may be held in accordance with the provisions of its laws by the vote of delegates or representatives of voting members or by the vote of local lodges. A society may provide for voting by mail. No amendment submitted for adoption by referendum shall be adopted unless, within six (6) months from the date of the submission thereof, a majority of the members voting shall have signified their consent to such amendment by one of the methods herein specified.

B. No amendment to the laws of any domestic society shall take effect unless approved by the Insurance Commissioner who shall approve such amendment if the Commissioner finds that it has been duly adopted and is not inconsistent with any requirement of the

laws of this state or with the character, objects and purposes of the society. Unless the Commissioner shall disapprove any such amendment within sixty (60) days after the filing of same, such amendment shall be considered approved. The approval or disapproval of the Commissioner shall be in writing and mailed to the secretary or corresponding officer of the society at its principal office. In case the Commissioner disapproves such amendment, the reasons therefor shall be stated in such written notice.

C. Within ninety (90) days from the approval thereof by the Commissioner, all such amendments, or a synopsis thereof, shall be furnished to all members of the society either by mail or by publication in full in the official publication of the society. The affidavit of any officer of the society or of anyone authorized by it to mail any amendments or synopsis thereof, stating facts which show that same have been duly addressed and mailed, shall be prima facie evidence that such amendments or synopsis thereof, have been furnished the addressee.

D. Every foreign or alien society authorized to do business in this state shall file with the Commissioner a duly certified copy of all amendments of, or additions to, its laws within ninety (90) days after enactment.

E. Printed copies of the laws as amended, certified by the secretary or corresponding officer of the society, shall be prima facie evidence of the legal adoption thereof.

Added by Laws 1992, c. 76, § 11, eff. Jan. 1, 1993.

§36-2712. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2712.1. Institutions.

A society may create, maintain and operate, or may establish organizations to operate, not for profit institutions to further the purposes permitted by paragraph 2 of subsection A of Section 5 of this act. Such institutions may furnish services free or at a reasonable charge. Any real or personal property owned, held or leased by the society for this purpose shall be reported in every annual statement, but shall not be allowed as an admitted society asset. No society shall own or operate funeral homes or undertaking establishments.

Added by Laws 1992, c. 76, § 12, eff. Jan. 1, 1993.

§36-2713. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2713.1. Reinsurance.

A. A domestic society may, by a reinsurance agreement, cede any individual risk or risks in whole or in part to an insurer, other than another fraternal benefit society, having the power to make such reinsurance and authorized to do business in this state, or if

not so authorized, one which is approved by the Insurance Commissioner; provided, no such society may reinsure substantially all of its insurance in force without the written permission of the Commissioner. It may take credit for the reserves on such ceded risks to the extent reinsured, but no credit shall be allowed as an admitted asset or as a deduction from liability, to a ceding society for reinsurance made, ceded, renewed, or otherwise becoming effective after the effective date of this act, unless the reinsurance is payable by the assuming insured on the basis of the liability of the ceding society under the contract or contracts reinsured without diminution because of the insolvency of the ceding society.

B. Notwithstanding the limitation in subsection A of this section, a society may reinsure the risks of another society in a consolidation or merger approved by the Commissioner under Section 14 of this act.

Added by Laws 1992, c. 76, § 13, eff. Jan. 1, 1993.

§36-2714. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2714.1. Consolidations and mergers.

A. A domestic society may consolidate or merge with any other society by complying with the provisions of this section. It shall file with the Insurance Commissioner:

1. A certified copy of the written contract containing in full the terms and conditions of the consolidation or merger;

2. A sworn statement by the president and secretary or corresponding officers of each society showing the financial condition thereof on a date fixed by the Commissioner but not earlier than December 31 next preceding the date of the contract;

3. A certificate of such officers, duly verified by their respective oaths, that the consolidation or merger has been approved by a two-thirds (2/3) vote of the supreme governing body of each society, such vote being conducted at a regular or special meeting of each such body, or, if the society's laws so permit, by mail; and

4. Evidence that at least sixty (60) days prior to the action of the supreme governing body of each society, the text of the contract has been furnished to all members of each society either by mail or by publication in full in the official publication of each society.

B. If the Commissioner finds that the contract is in conformity with the provisions of this section, that the financial statements are correct and that the consolidation or merger is just and equitable to the members of each society, the Commissioner shall approve the contract and issue a certificate to such effect. Upon approval, the contract shall be in full force and effect unless any society which is a party to the contract is incorporated under the

laws of any other state or territory. In such event the consolidation or merger shall not become effective unless and until it has been approved as provided by the laws of such state or territory and a certificate of the approval is filed with the Commissioner of this state or, if the laws of such state or territory contain no such provision, then the consolidation or merger shall not become effective unless and until it has been approved by the Commissioner of such state or territory and a certificate of approval filed with the Commissioner of this state. In case the contract is not approved it shall be inoperative, and the fact of the submission and its contents shall not be disclosed by the Commissioner.

C. Upon the consolidation or merger becoming effective as herein provided, all the rights, franchises and interests of the consolidated or merged societies in and to every species of property, real, personal or mixed, and things in action thereunto belonging shall be vested in the society resulting from or remaining after the consolidation or merger without any other instrument, except that conveyances of real property may be evidenced by proper deeds, and the title to any real estate or interest therein, vested under the laws of this state in any of the societies consolidated or merged, shall not revert or be in any way impaired by reason of the consolidation or merger, but shall vest absolutely in the society resulting from or remaining after such consolidation or merger.

D. The affidavit of any officer of the society or of anyone authorized by it to mail any notice or document, stating that such notice or document has been duly addressed and mailed, shall be prima facie evidence that such notice or document has been furnished the addressees.

Added by Laws 1992, c. 76, § 14, eff. Jan. 1, 1993.

§36-2715. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2715.1. Conversion of fraternal benefit society into mutual life insurance company or stock legal reserve life insurance company.

A. Any domestic fraternal benefit society may be converted and licensed as a mutual life insurance company by compliance with all the requirements of the general insurance laws for mutual life insurance companies. A plan of conversion shall be prepared in writing by the board of directors setting forth in full the terms and conditions of conversion. The affirmative vote of two-thirds (2/3) of all members of the supreme governing body at a regular or special meeting shall be necessary for approval of the plan. No conversion shall take effect unless and until approved by the Insurance Commissioner who may give approval if the Commissioner finds that the proposed change is in conformity with the

requirements of law and not prejudicial to the certificate holders of the society.

B. Any domestic fraternal benefit society may be converted and licensed as a stock legal reserve life insurance company by compliance with all the requirements of the applicable provisions of the Insurance Code if such plan of conversion has been approved by the Commissioner. Such plan shall be prepared in writing setting forth in full the terms and conditions thereof. The board of directors shall submit the plan to the supreme legislative or governing body of the society at any regular or special meeting thereof, by giving a full, true, and complete copy of the plan together with notice of the meeting. The notice shall be given as provided in the laws of the society for the convocation of a regular or special meeting of the governing body, as the case may be. The affirmative vote of two-thirds (2/3) of all members of the governing body shall be necessary for the approval of the agreement. No conversion shall take effect unless and until approved by the Commissioner who may give approval if the Commissioner finds that the proposed change is in conformity with the requirements of law and not prejudicial to the certificate holders of the society. If such fraternal benefit society is converted into a stock legal reserve life insurance company, each and every certificate holder shall be entitled to purchase that proportion of the total capital stock of the company as the amount of his insurance in force bears to the society's total insurance in force and outstanding at the time the Commissioner approved the proposed plan of conversion. Each certificate holder shall have the exclusive right to purchase said stock within thirty (30) days after receiving notice from the society of such right and the fact that the conversion has been approved by the membership. Any stock not purchased by the certificate holders may then be sold by the board of directors. Added by Laws 1992, c. 76, § 15, eff. Jan. 1, 1993.

§36-2716. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2716.1. Benefits.

A. A society may provide the following contractual benefits in any form:

1. Death benefits;
2. Endowment benefits;
3. Annuity benefits;
4. Temporary or permanent disability benefits;
5. Hospital, medical or nursing benefits;
6. Monument or tombstone benefits to the memory of deceased members; and
7. Such other benefits as authorized for life insurers and which are not inconsistent with this article.

B. A society shall specify in its rules those persons who may be issued, or covered by, the contractual benefits in subsection A of this section, consistent with providing benefits to members and their dependents. A society may provide benefits on the lives of children under the minimum age for adult membership upon application of an adult person.

Added by Laws 1992, c. 76, § 16, eff. Jan. 1, 1993.

§36-2717. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2717.1. Beneficiaries.

A. The owner of a benefit contract shall have the right at all times to change the beneficiary or beneficiaries in accordance with the laws or rules of the society unless the owner waives this right by specifically requesting in writing that the beneficiary designation be irrevocable. A society may, through its laws or rules, limit the scope of beneficiary designations and shall provide that no revocable beneficiary shall have or obtain any vested interest in the proceeds of any certificate until the certificate has become due and payable in conformity with the provisions of the benefit contract.

B. A society may make provision for the payment of funeral benefits to the extent of such portion of any payment under a certificate as might reasonably appear to be due to any person equitably entitled thereto by reason of having incurred expense occasioned by the burial of the member; provided, the payment shall not exceed the sum of Fifteen Thousand Dollars (\$15,000.00).

C. If, at the death of any member, there is no lawful beneficiary to whom the insurance benefits are payable, the amount of such benefits, except to the extent that funeral benefits may be paid as hereinbefore provided, shall be payable to the personal representative of the deceased insured; provided, if the owner of the certificate is other than the insured, such proceeds shall be payable to such owner.

Added by Laws 1992, c. 76, § 17, eff. Jan. 1, 1993.

§36-2718. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2718.1. Benefits not attachable.

No money or other benefit, charity, relief or aid to be paid, provided or rendered by any society, shall be liable to attachment, garnishment or other process, or to be seized, taken, appropriated or applied by any legal or equitable process or operation of law to pay any debt or liability of a member or beneficiary, or any other person who may have a right thereunder, either before or after payment by the society.

Added by Laws 1992, c. 76, § 18, eff. Jan. 1, 1993.

§36-2719. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2719.1. Benefit contract - Standard provision requirements.

A. Every society authorized to do business in this state shall issue to each owner of a benefit contract a certificate specifying the amount of benefits provided thereby. The certificate, together with any riders or endorsements attached thereto, the laws of the society, the application for membership, the application for insurance and declaration of insurability, if any, signed by the applicant, and all amendments to each, shall constitute the benefit contract, as of the date of issuance, between the society and the owner, and the certificate shall so state. A copy of the application for insurance and declaration of insurability, if any, shall be endorsed upon or attached to the certificate. All statements on the application shall be representations and not warranties. Any waiver of this provision shall be void.

B. Any changes, additions or amendments to the laws of the society duly made or enacted subsequent to the issuance of the certificate shall bind the owner and the beneficiaries, and shall govern and control the benefit contract in all respects the same as though such changes, additions or amendments had been made prior to and were in force at the time of the application for insurance, except that no change, addition or amendment shall destroy or diminish benefits which the society contracted to give the owner as of the date of issuance.

C. Any person upon whose life a benefit contract is issued prior to attaining the age of majority shall be bound by the terms of the application and certificate and by all the laws and rules of the society to the same extent as though the age of majority had been attained at the time of application.

D. A society shall provide in its laws that if its reserves as to all or any class of certificates become impaired, its board of directors or corresponding body may require that there shall be paid by the owner of the certificate to the society the amount of the owner's equitable proportion of the deficiency as ascertained by its board, and that if the payment is not made, either:

1. It shall stand as an indebtedness against the certificate and draw interest not to exceed the rate specified for certificate loans under the certificates; or

2. In lieu of or in combination with the provisions of paragraph 1 of this subsection, the owner may accept a proportionate reduction in benefits under the certificate.

The society may specify the manner of the election and which alternative is to be presumed if no election is made.

E. Copies of any of the documents mentioned in this section, certified by the secretary or corresponding officer of the society, shall be received as evidence of the terms and conditions thereof.

F. No certificate shall be delivered or issued for delivery in this state unless a copy of the form has been filed with and approved by the Insurance Commissioner in the manner provided for like policies issued by life insurers in this state. Every life, accident, health, or disability insurance certificate and every annuity certificate issued on or after one (1) year from the effective date of this act shall meet the standard contract provision requirements not inconsistent with this article for like policies issued by life insurers in this state, except that a society may provide for a grace period for payment of premiums of one (1) full month in its certificates. The certificate shall also contain a provision stating the amount of premiums which are payable under the certificate and a provision reciting or setting forth the substance of any sections of the society's laws or rules in force at the time of issuance of the certificate which, if violated, will result in the termination or reduction of benefits payable under the certificate. If the laws of the society provide for expulsion or suspension of a member, the certificate shall also contain a provision that any member so expelled or suspended, except for nonpayment of a premium or within the contestable period for material misrepresentation in the application for membership or insurance, shall have the privilege of maintaining the certificate in force by continuing payment of the required premium.

G. Benefit contracts issued on the lives of persons below the society's minimum age for adult membership may provide for transfer of control or ownership to the insured at an age specified in the certificate. A society may require approval of an application for membership in order to effect this transfer, and may provide in all other respects for the regulation, government and control of such certificates and all rights, obligations and liabilities incident thereto and connected therewith. Ownership rights prior to such transfer shall be specified in the certificate.

H. A society may specify the terms and conditions on which benefit contracts may be assigned.

Added by Laws 1992, c. 76, § 19, eff. Jan. 1, 1993.

§36-2720. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2720.1. Nonforfeiture benefits - Cash surrender values - Certificate loans or other options.

A. For certificates issued prior to one (1) year after the effective date of this act, the value of every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan or other

option granted shall comply with the provisions of law applicable immediately prior to the effective date of this act.

B. For certificates issued on or after one (1) year from the effective date of this act for which reserves are computed on the Insurance Commissioner's 1941 Standard Ordinary Mortality Table, the Commissioner's 1941 Standard Industrial Table, the Commissioner's 1958 Standard Ordinary Mortality Table, or the Commissioner's 1980 Standard Mortality Table, or any more recent table made applicable to life insurers, every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan or other option granted shall not be less than the corresponding amount ascertained in accordance with the laws of this state applicable to life insurers issuing policies containing like benefits based upon such tables.

Added by Laws 1992, c. 76, § 20, eff. Jan. 1, 1993.

§36-2721. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2721.1. Investments.

A society shall invest its funds only in such investments as are authorized by the laws of this state for the investment of assets of life insurers and subject to the limitations thereon. Any foreign or alien society permitted or seeking to do business in this state which invests its funds in accordance with the laws of the state, district, territory, country or province in which it is incorporated, shall be held to meet the requirements of this section for the investment of funds.

Added by Laws 1992, c. 76, § 21, eff. Jan. 1, 1993.

§36-2722. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2722.1. Funds.

A. All assets shall be held, invested and disbursed for the use and benefit of the society and no member or beneficiary shall have or acquire individual rights therein or become entitled to any apportionment on the surrender of any part thereof, except as provided in the benefit contract.

B. A society may create, maintain, invest, disburse and apply any special fund or funds necessary to carry out any purpose permitted by the laws of such society.

C. A society may, pursuant to resolution of its supreme governing body, establish and operate one or more separate accounts and issue contracts on a variable basis, subject to the provisions of law regulating life insurers establishing such accounts and issuing such contracts. To the extent the society deems it necessary in order to comply with any applicable federal or state laws, or any rules issued thereunder, the society may adopt special procedures for the conduct of the business and affairs of a separate

account; may, for persons having beneficial interests therein, provide special voting and other rights, including, without limitation, special rights and procedures relating to investment policy, investment advisory services, selection of a licensed public accountant or a certified public accountant holding a permit to practice accounting, and selection of a committee to manage the business and affairs of the account; and may issue contracts on a variable basis to which subsections B and D of Section 19 of this act shall not apply.

Added by Laws 1992, c. 76, § 22, eff. Jan. 1, 1993.

§36-2723. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2723.1. Exemptions.

The provisions of this act apply only to fraternal benefit societies, and societies shall be governed by this act to the extent provided herein. Societies shall be exempt from all other provisions of the insurance laws of this state except that the provisions of Article 1 (Scope of Title), Article 3 (Insurance Department and Insurance Commissioner), Sections 606, 610, 612.1, 616, 617, 620 and 628 of Article 6 (Authorization of Insurers and General Requirements), Article 16 (Investments), Article 17 (Administration of Deposits), and Article 19 (Rehabilitation and Liquidation), of the Insurance Code, shall apply to societies to the extent that such provisions are not in conflict with the provisions of this article. No law relating to insurance hereafter enacted shall apply to societies unless they are expressly designated therein.

Added by Laws 1992, c. 76, § 23, eff. Jan. 1, 1993. Amended by Laws 2006, c. 264, § 57, eff. July 1, 2006.

§36-2724. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2724.1. Taxation.

Every society organized or licensed under this act is hereby declared to be a charitable and benevolent institution, and all of its funds shall be exempt from all and every state, county, district, municipal and school tax other than taxes on real estate and office equipment.

Added by Laws 1992, c. 76, § 24, eff. Jan. 1, 1993.

§36-2725. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2725.1. Standard of valuation.

A. Standards of valuation for certificates issued prior to one (1) year after the effective date of this act shall be those

provided by the laws applicable immediately prior to the effective date of this act.

B. The minimum standards of valuation for certificates issued on or after one (1) year from the effective date of this act shall be based on the following tables:

1. For certificates of life insurance - the Insurance Commissioner's 1941 Standard Ordinary Mortality Table, the Commissioner's 1941 Standard Industrial Mortality Table, the Commissioner's 1958 Standard Ordinary Mortality Table, the Commissioner's 1980 Standard Ordinary Mortality Table or any more recent table made applicable to life insurers; and

2. For annuity and pure endowment certificates, for total and permanent disability benefits, for accidental death benefits and for noncancellable accident and health benefits - such tables as are authorized for use by life insurers in this state.

All of the above shall be under valuation methods and standards, including interest assumptions, in accordance with the laws of this state applicable to life insurers issuing policies containing like benefits.

C. The Insurance Commissioner may, in his or her discretion, accept other standards for valuation if the Commissioner finds that the reserves produced thereby will not be less in the aggregate than reserves computed in accordance with the minimum valuation standard herein prescribed. The Commissioner may, in his or her discretion, vary the standards of mortality applicable to all benefit contracts on substandard lives or other extrahazardous lives by any society authorized to do business in this state.

D. Any society, with the consent of the commissioner of insurance of the state of domicile of the society and under such conditions, if any, which such commissioner may impose, may establish and maintain reserves on its certificates in excess of the reserves required thereunder, but the contractual rights of any benefit member shall not be affected thereby.

Added by Laws 1992, c. 76, § 25, eff. Jan. 1, 1993.

§36-2726. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2726.1. Reports.

A. Reports shall be filed in accordance with the following provisions:

1. Every society transacting business in this state shall annually, on or before the first day of March, unless for cause shown such time has been extended by the Insurance Commissioner, file with the Commissioner a true statement of its financial condition, transactions and affairs for the preceding calendar year and pay the fee therefor stated in Section 321 of this title. The statement shall be in general form and context as approved by the

National Association of Insurance Commissioners for fraternal benefit societies as supplemented by the Commissioner by rule.

2. As part of the annual statement herein required, each society shall, on or before the first day of March, file with the Commissioner a valuation of its certificates in force on the immediately preceding December 31; provided, the Commissioner may, in his or her discretion for cause shown, extend the time for filing such valuation for not more than two (2) calendar months. Such valuation shall be done in accordance with the standards specified in Section 2725.1 of this title. Such valuation and underlying data shall be certified by a qualified actuary or, at the expense of the society, verified by the actuary of the department of insurance of the state of domicile of the society.

B. A society neglecting to file the annual statement in the form and within the time provided by this section shall forfeit One Hundred Dollars (\$100.00) for each day during which such neglect continues, and, on notice by the Insurance Commissioner to that effect, its authority to do business in this state shall cease while such default continues.

Added by Laws 1992, c. 76, § 26, eff. Jan. 1, 1993. Amended by Laws 1997, c. 418, § 93, eff. Nov. 1, 1997.

§36-2727. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2727.1. Annual license.

Societies which are authorized prior to the effective date of this act to transact business in this state may continue such business until the last day of February next succeeding the effective date of this act. The authority of such societies and of all societies licensed on and after the effective date of this act may be renewed annually, to terminate in all cases on the last day of the succeeding February. However, a license so issued shall continue in full force and effect until the new license is issued or specifically refused. For each such license or renewal the society shall pay to the Insurance Commissioner the fee stated in Section 321 of Title 36 of the Oklahoma Statutes. A duly certified copy or duplicate of such license shall be prima facie evidence that the licensee is a fraternal benefit society within the meaning of this article.

Added by Laws 1992, c. 76, § 27, eff. Jan. 1, 1993.

§36-2728. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2728.1. Examination of domestic, foreign or alien societies.

A. The Insurance Commissioner, or a designee, may examine any domestic, foreign or alien society transacting or applying for admission to transact business in this state in the same manner as

authorized for examination of domestic, foreign or alien insurers. Requirements of notice and an opportunity to respond before findings are made public as provided in the laws regulating insurers shall also be applicable to the examination of societies.

B. The expense of each examination and of each valuation, including compensation and actual expense of examiners, shall be paid by the society examined or whose certificates are valued, upon statements furnished by the Commissioner.

Added by Laws 1992, c. 76, § 28, eff. Jan. 1, 1993.

§36-2729. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2729.1. Foreign or alien society - Admission.

A. No foreign or alien society shall transact business in this state without a license issued by the Insurance Commissioner. Any society desiring admission to this state shall comply substantially with the requirements and limitations of this act applicable to domestic societies. Any such society may be licensed to transact business in this state upon filing with the Commissioner:

1. A duly certified copy of its articles of incorporation;

2. A copy of its bylaws, certified by its secretary or corresponding officer;

3. A power of attorney to the Commissioner as prescribed in Section 35 of this act;

4. A statement of its business under oath of its president and secretary or corresponding officers in a form prescribed by the Commissioner, duly verified by an examination made by the supervising insurance official of its home state or other state, territory, province or country, satisfactory to the Insurance Commissioner of this state;

5. Certification from the proper official of its home state, territory, province or country that the society is legally incorporated and licensed to transact business therein;

6. Copies of its certificate forms;

7. Such other information as the Commissioner may deem necessary; and

8. Information showing that its assets are invested in accordance with the provisions of this act.

B. Any foreign or alien society desiring admission to the state shall have the qualifications required of domestic societies organized under this article.

Added by Laws 1992, c. 76, § 29, eff. Jan. 1, 1993.

§36-2730. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2730.1. Injunction, liquidation or receivership of domestic society.

A. When the Insurance Commissioner upon investigation finds that a domestic society:

1. Has exceeded its powers;
 2. Has failed to comply with any provision of this article;
 3. Is not fulfilling its contracts in good faith;
 4. Has a membership of less than four hundred after an existence of one (1) year or more; or
 5. Is conducting business fraudulently or in a manner hazardous to its members, creditors, the public or the business;
- the Commissioner shall notify the society of such deficiency or deficiencies and state in writing the reasons for his or her dissatisfaction. The Commissioner shall at once issue a written notice to the society requiring that the deficiency or deficiencies be corrected. After such notice, the society shall have a thirty-day period in which to comply with the Commissioner's request for correction. If the society fails to comply with such request, the Commissioner shall notify the society of such findings of noncompliance and require the society to show cause on a date named why it should not be enjoined from carrying on any business until the violation complained of shall have been corrected, or why an action in the nature of quo warranto should not be commenced against the society.

B. If on such date the society does not present good and sufficient reasons why it should not be so enjoined or why such action should not be commenced, the Commissioner may present the facts relating thereto to the Attorney General who shall, if he or she deems the circumstances warrant, commence an action to enjoin the society from transacting business or an action in the nature of quo warranto.

C. The court shall thereupon notify the officers of the society of a hearing. If, after a full hearing, it appears that the society should be so enjoined or liquidated or a receiver appointed, the court shall enter the necessary order. No society so enjoined shall have the authority to do business until:

1. The Commissioner finds that the violation complained of has been corrected;
2. The costs of such action shall have been paid by the society if the court finds that the society was in default as charged;
3. The court has dissolved its injunction; and
4. The Commissioner has reinstated the certificate of authority.

D. If the court orders the society liquidated, it shall be enjoined from carrying on any further business, whereupon the receiver of the society shall proceed at once to take possession of the books, papers, money and other assets of the society and, under the direction of the court, proceed forthwith to close the affairs of the society and to distribute its funds to those entitled.

E. No action under this section shall be recognized in any court of this state unless brought by the Attorney General upon request of the Commissioner. Whenever a receiver is to be appointed for a domestic society, the court shall appoint the Commissioner as the receiver.

F. The provisions of this section relating to hearing by the Commissioner, action by the Attorney General at the request of the Commissioner, hearing by the court, injunction and receivership shall be applicable to a society which shall voluntarily determine to discontinue business.

Added by Laws 1992, c. 76, § 30, eff. Jan. 1, 1993.

§36-2731. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2731.1. Suspension, revocation or refusal of license of foreign or alien society.

A. When the Insurance Commissioner upon investigation finds that a foreign or alien society transacting or applying to transact business in this state:

1. Has exceeded its powers;
2. Has failed to comply with any of the provisions of this article;
3. Is not fulfilling its contracts in good faith; or
4. Is conducting its business fraudulently or in a manner hazardous to its members or creditors or the public;

the Insurance Commissioner shall notify the society of such deficiency or deficiencies and state in writing the reasons for his or her dissatisfaction. The Commissioner shall at once issue a written notice to the society requiring that the deficiency or deficiencies be corrected. After such notice, the society shall have a thirty-day period in which to comply with the Commissioner's request for correction. If the society fails to comply with the request, the Commissioner shall notify the society of the noncompliance and require the society to show cause on a date named why its license should not be suspended, revoked or refused. If on such date the society does not present good and sufficient reason why its authority to do business in this state should not be suspended, revoked or refused, the Commissioner may suspend or refuse the license of the society to do business in this state until satisfactory evidence is furnished to the Commissioner that such suspension or refusal should be withdrawn, or the Commissioner may revoke the authority of the society to do business in this state.

B. Nothing contained in this section shall be taken or construed as preventing any such society from continuing in good faith all contracts made in this state during the time such society was legally authorized to transact business herein.

Added by Laws 1992, c. 76, § 31, eff. Jan. 1, 1993.

§36-2732. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2732.1. Injunction - Authority to petition for.

No application or petition for injunction against any domestic, foreign or alien society, or lodge thereof, shall be recognized in any court of this state unless made by the Attorney General upon request of the Insurance Commissioner.

Added by Laws 1992, c. 76, § 32, eff. Jan. 1, 1993.

§36-2733. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2733.1. Licensing of agents.

A. Agents of societies shall be licensed in accordance with the provisions of Article 14A of the Insurance Code regulating the licensing, revocation, suspension or termination of licenses of resident and nonresident agents; provided, no examination shall be required of any such agent licensed prior to the effective date of this act.

B. No examination or license shall be required of any regular salaried officer, employee or member of a licensed society who devotes substantially all of his or her services to activities other than the solicitation of fraternal insurance contracts from the public, and who receives for the solicitation of such contracts no commission or other compensation directly dependent upon the amount of business obtained.

C. Any agent or representative of a society who devotes, or intends to devote, less than fifty percent (50%) of his or her time to solicitation and procurement of insurance contracts for the society shall be exempt from the requirements of subsection A of this section. Provided, however, any person who in the immediately preceding calendar year solicited and procured life insurance contracts on behalf of any society in an amount of insurance in excess of Fifty Thousand Dollars (\$50,000.00), or, in the case of any other kinds of insurance which the society writes, on the persons of more than twenty-five individuals, and who received or will receive a commission or other compensation therefor, is presumed to be devoting or intending to devote fifty percent (50%) of his or her time to the solicitation or procurement of insurance contracts for the society.

Added by Laws 1992, c. 76, § 33, eff. Jan. 1, 1993.

§36-2734. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2734.1. Societies subject to Article 12, Unfair Practices and Frauds.

Every society authorized to do business in this state shall be subject to Article 12 of the Insurance Code, Unfair Practices and Frauds. Provided, however, nothing in such provisions shall be construed as applying to or affecting the right of any society to determine its eligibility requirements for membership, or be construed as applying to or affecting the offering of benefits exclusively to members or persons eligible for membership in the society by a subsidiary corporation or affiliated organization of the society.

Added by Laws 1992, c. 76, § 34, eff. Jan. 1, 1993.

§36-2735. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2735.1. Service of process.

A. Every society authorized to do business in this state shall appoint in writing the Insurance Commissioner and each successor in office to be its true and lawful attorney upon whom all lawful process in any action or proceeding against it shall be served, and shall agree in writing that any lawful process against it which is served on said attorney shall be of the same legal force and validity as if served upon the society, and that the authority shall continue in force so long as any liability remains outstanding in this state. Copies of the appointment, certified by said Commissioner, shall be deemed sufficient evidence thereof and shall be admitted in evidence with the same force and effect as the original thereof might be admitted.

B. Service shall only be made upon the Commissioner, or if absent, upon the person in charge of the Commissioner's office. It shall be made in triplicate and shall constitute sufficient service upon the society. When legal process against a society is served upon the Commissioner, the Commissioner shall forthwith forward one of the triplicate copies by registered mail, prepaid, directed to the secretary or corresponding officer. No such service shall require a society to file its answer, pleading or defense in less than thirty (30) days from the date of mailing the copy of the service to a society. Legal process shall not be served upon a society except in the manner herein provided. At the time of serving any process upon the Commissioner, the plaintiff or complainant in the action shall pay to the Commissioner a fee of Ten Dollars (\$10.00).

Added by Laws 1992, c. 76, § 35, eff. Jan. 1, 1993.

§36-2736. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2736.1. Repealed by Laws 1997, c. 418, § 125, eff. Nov. 1, 1997.

§36-2737. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2737.1. Penalties.

A. Any person who willfully makes a false or fraudulent statement in or relating to an application for membership or for the purpose of obtaining money from or a benefit in any society, upon conviction, shall be guilty of a misdemeanor, punishable by a fine of not less than One Hundred Dollars (\$100.00) nor more than One Thousand Dollars (\$1,000.00) or by imprisonment in the county jail for not less than thirty (30) days nor more than one (1) year, or both.

B. Any person who willfully makes a false or fraudulent statement in any verified report or declaration under oath required or authorized by this article, or of any material fact or thing contained in a sworn statement concerning the death or disability of a member for the purpose of procuring payment of a benefit named in the certificate, is guilty of the felony of perjury and is subject to the penalties therefor prescribed by law.

C. Any person who solicits membership for, or in any manner assists in procuring membership in, any society not licensed to do business in this state, upon conviction, shall be fined not less than Fifty Dollars (\$50.00) nor more than Five Hundred Dollars (\$500.00).

D. Any person guilty of a willful violation of, or neglect of or refusal to comply with, the provisions of this article for which a penalty is not otherwise prescribed, shall, upon conviction, be subject to a fine not exceeding One Thousand Dollars (\$1,000.00). Added by Laws 1992, c. 76, § 37, eff. Jan. 1, 1993. Amended by Laws 1997, c. 133, § 449, eff. July 1, 1999.

NOTE: Laws 1998, 1st Ex.Sess., c. 2, § 23 amended the effective date of Laws 1997, c. 133, § 449 from July 1, 1998, to July 1, 1999.

§36-2738. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2738.1. Exemption of certain societies.

A. Nothing contained in this article shall be so construed as to affect or apply to:

1. Grand or subordinate lodges of societies, orders or associations now doing business in this state which provide benefits exclusively through local or subordinate lodges;

2. Orders, societies or associations which admit to membership only persons engaged in one or more crafts or hazardous occupations, in the same or similar lines of business, insuring only their own members and their families, and the ladies' societies or ladies' auxiliaries to such orders, societies or associations;

3. Domestic societies which limit their membership to employees of a particular city or town, designated firm, business house or

corporation which provide for a death benefit of not more than Four Hundred Dollars (\$400.00) or disability benefits of not more than Three Hundred Fifty Dollars (\$350.00) to any person in any one (1) year, or both; or

4. Domestic societies or associations of a purely religious, charitable or benevolent description, which provide for a death benefit of not more than Four Hundred Dollars (\$400.00) or for disability benefits of not more than Three Hundred Fifty Dollars (\$350.00) to any one person in any one (1) year, or both.

B. Any such society or association described in paragraph 3 or paragraph 4 of subsection A of this section which provides for death or disability benefits for which benefit certificates are issued, and any such society or association included in subsection D of this section which has more than one thousand members, shall not be exempted from the provisions of this article but shall comply with all requirements thereof.

C. No society which, by the provisions of this section, is exempt from the requirements of this article, except any society described in paragraph 2 of subsection A of this section, shall give or allow or promise to give or allow to any person any compensation for procuring new members.

D. Every society which provides for benefits in case of death or disability resulting solely from accident, and which does not obligate itself to pay natural death or sick benefits shall have all of the privileges and be subject to all the applicable provisions and regulations of this article; provided, however, the provisions thereof relating to medical examination, valuations of benefit certificates, and incontestability, shall not apply to such society.

E. The Insurance Commissioner may require from any society or association, by examination or otherwise, such information as will enable the Commissioner to determine whether such society or association is exempt from the provisions of this article.

F. Societies, exempted under the provisions of this section, shall also be exempt from all other provisions of the insurance laws of this state.

Added by Laws 1992, c. 76, § 38, eff. Jan. 1, 1993.

§36-2739. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2740. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2741. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2742. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2743. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2744. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2745. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2746. Repealed by Laws 1992, c. 76, § 39, eff. Jan. 1, 1993.

§36-2801. Organization authorized - Purposes - Power to make assessments.

Any fifty or more persons of lawful age, who shall be resident, bona fide farmers, and collectively shall own property of not less than Twenty-five Thousand Dollars (\$25,000.00), which they desire to have insured, may associate themselves together for the purpose of insuring any or all property located in this state, as provided in this article, against loss by fire, lightning, tornado, and theft, and against property and liability loss and to provide extended coverage, and they may assess upon and collect from each other such sums of money as from time to time may be necessary to pay losses, occurring from fire, lightning, tornado, and theft, property and liability loss and protection for the events provided by extended coverage insurance, to insured members of such associations. The assessment and collection of such sums of money shall be prescribed and regulated by the bylaws of such association. Such associations shall comply with all provisions of the Insurance Code not inconsistent with the provisions of this article.

Added by Laws 1957, p. 352, § 2801, operative July 1, 1957. Amended by Laws 1963, c. 120, § 1, emerg. eff. June 3, 1963; Laws 1975, c. 241, § 1, emerg. eff. May 30, 1975; Laws 1984, c. 149, § 12, eff. Nov. 1, 1984; Laws 1986, c. 251, § 38, eff. Nov. 1, 1986; Laws 1995, c. 6, § 1, emerg. eff. March 27, 1995; Laws 2004, c. 21, § 1, eff. Nov. 1, 2004; Laws 2006, c. 246, § 1, eff. Nov. 1, 2006.

§36-2802. Certificate by incorporators - Contents.

Such persons shall make and subscribe to a certificate setting forth therein:

First. The name by which the association shall be known.

Second. A central office or business address.

Third. That the object of the association shall be only the one contemplated in this article.

Fourth. The names and addresses of at least ten persons organizing the same.

Fifth. Agreeing that the association shall insure and enforce only those contracts which may be by them entered into by which the beneficiaries entering therein shall agree to be assessed for incidental expenses and for the payment of losses to insured members for loss to property by casualty contemplated in this article.

Added by Laws 1957, p. 352, § 2802, operative July 1, 1957.

§36-2803. Filing certificate with Insurance Commissioner; officers; terms.

Such certificate shall be filed with the Insurance Commissioner, and a certified copy thereof signed by the Insurance Commissioner shall be evidence of the due incorporation and existence of such association for the purpose therein named, whereupon, the persons named in such certificate and the other members of such association may elect a president, secretary, treasurer, and not less than five nor more than fifteen directors, and such other officers as may be deemed necessary for the complete performance of all business and objects of the association. Such officers shall be chosen for a term of not more than one (1) year, and their successors shall be thereafter chosen in such time and manner as shall be prescribed by the bylaws; but no term, terms, or tenure shall be longer than three (3) years.

Laws 1957, p. 353, § 2803; Laws 1963, c. 120, § 2, emerg. eff. June 3, 1963.

§36-2804. Made a body corporate.

Every such association shall be a body corporate for said purposes, and may sue and be sued and be vested with legal rights and powers in like manner as other corporations of this state.

Laws 1957, p. 353, § 2804.

§36-2805. Restrictions as to corporate acts.

Every such association shall not insure other than its own members; issue capital stock or have any capitalization whatsoever; be run or conducted for profit to any member or person whomsoever; pay any salary or compensation to its president, secretary, treasurer, board of directors, or other officer or person, except as in this article provided; pass or enact any bylaw creating different classes of membership or depriving any member of the full rights of suffrage therein.

Laws 1957, p. 353, Sec. 2805.

§36-2806. Bylaws; permit to do business.

Every such association shall adopt such bylaws not inconsistent with the laws of this state and of the United States, which, in the judgment of its members will best subserve the interests and purposes of the association. The members of every such association shall be held by the laws of this state to comply with all the provisions and requirements of such bylaws, and the terms of their policies of insurance shall be deemed to carry such bylaws, as a part thereof and shall so specify. The bylaws shall contain a form of certificate of insurance to be used. A copy of all bylaws adopted, all amendments, and changes therein shall be filed with the Insurance Commissioner, for his approval, before becoming effective,

together with a list of the members at the time of organization. When such association has been duly organized and has adopted bylaws in accordance herewith, the Insurance Commissioner shall issue his certificate to that effect, whereupon such association may commence business and grant insurance.

Laws 1957, p. 353, § 2806.

§36-2807. Membership - Forfeiture.

After any such association is organized and has commenced business, its membership shall be composed of its policyholders only, and every person accepted as insurable shall be ipso facto a member. Noncompliance with the bylaws and nonpayment of assessments within thirty days after request so to do shall forfeit member's policy and membership; provided, such member shall be held liable for his pro rata share of any liability existing at the time his membership is forfeited.

Added by Laws 1957, p. 353, § 2807, operative July 1, 1957.

§36-2808. Rejection and termination of risks.

The board of directors shall have the right and power to reject any person, or any risk or part thereof; also to terminate any membership and any insurance, or part of any insurance, at any time, upon ten days notice to such member.

Laws 1957, p. 353, § 2808.

§36-2809. Incidental expenses.

The bylaws shall provide for sufficient assessment to pay for stationery, blanks, printing, postage, viewing and appraising losses, and such other incidental expenses as may be necessary to conduct the business of such association.

Laws 1957, p. 353, § 2809.

§36-2810. Compensation of officers.

Compensation of officers shall be as provided in the bylaws, and shall not exceed the sum of Ten Thousand Dollars (\$10,000.00) per annum for the president. Compensation of other officers and employees shall be fixed by the board of directors at a reasonable amount for services rendered.

Amended by Laws 1986, c. 251, § 39, eff. Nov. 1, 1986. Amended by Laws 1986, c. 251, § 39, eff. Nov. 1, 1986.

§36-2811. Annual reports to Commissioner; reissuance of certificate; fees.

Every such association shall annually, on or before March first, render a statement in writing to the Insurance Commissioner, showing the status of such company at the close of business on December 31st, next preceding; the names and addresses of its officers; the

number of members; amount of insurance in force; the county or counties wherein property insured is located; the number of losses, amounts claimed for losses, appraisalment of loss, amounts paid to beneficiaries, amounts collected from members, the percentage of assessments to the total amount of insurance in force; the amount of losses due and unpaid, why unpaid; the amount of losses contested, rejected, resisted or reduced, and why so contested, rejected, resisted or reduced; and any other information which shall be required of it by the Insurance Commissioner, which statement shall be sworn to by the president or vice-president and secretary. Upon receipt of such annual statement, the Insurance Commissioner shall annually reissue a certificate to every such association, if, upon examination he is of the opinion that such association is doing business in compliance with the provisions of this article. Every such association may publish once yearly in weekly newspaper of general circulation in the county of its business and post office address, the annual certificate issued to it by the Insurance Commissioner, authorizing it to continue business.
Laws 1957, p. 354, § 2811.

§36-2812. Extension of membership.

Nothing in this article shall prevent the membership of any association from being extended from one county to another provided the said county into which said membership is extended shall not cover a territory greater than forty-five counties, nor shall anything in this article be construed to repeal or conflict with any law of this state controlling mutual insurance companies engaged in writing risks in this state.
Amended by Laws 1986, c. 251, § 40, eff. Nov. 1, 1986.

§36-2813. Applicability.

The provisions of this article apply only to farmers' mutual fire insurance associations and such associations shall be governed by this article to the extent provided herein. Such associations shall comply with all provisions of the Insurance Code to the extent that such provisions are not in conflict with the provisions of this article.
Added by Laws 1957, p. 354, § 2813, operative July 1, 1957. Amended by Laws 1975, c. 241, § 2, emerg. eff. May 30, 1975; Laws 2006, c. 246, § 2, eff. Nov. 1, 2006.
NOTE: Laws 2006, c. 264, § 58 repealed by Laws 2007, c. 1, § 22, emerg. eff. Feb. 22, 2007.

§36-2814. Formation of additional companies prohibited.

No farmers' mutual fire insurance associations shall be formed after the effective date of this act, nor shall the Insurance Commissioner after said effective date issue a permit to organize

such an association to or approve any articles of incorporation of any group of individuals desiring to organize an association or company under the provisions of this article.

Laws 1963, c. 120, § 5, emerg. eff. June 3, 1963.

§36-2815. Prohibition on transfer or sale of certificates, authority, or articles.

No certificate, or authority, or articles of incorporation of a farmers' mutual fire insurance association shall be transferred, sold, or otherwise exchanged or traded.

Laws 1963, c. 120, § 6, emerg. eff. June 3, 1963.

§36-2901. "Reciprocal" insurance defined.

"Reciprocal" insurance is that resulting from an inter-exchange among persons, known as "subscribers," of reciprocal agreement of indemnity, the inter-exchange being effectuated through an "attorney-in-fact" common to all such persons.

Laws 1957, p. 354, § 2901.

§36-2902. "Reciprocal insurer" defined.

A "reciprocal insurer" means an unincorporated aggregation of subscribers operating individually and collectively through an attorney-in-fact to provide reciprocal insurance among themselves.

Laws 1957, p. 354, § 2902.

§36-2903. Scope of article; existing insurers.

A. All authorized reciprocal insurers shall be governed by those sections of this article not expressly made applicable to domestic reciprocals only.

B. To the extent not modified by the provisions of this article, reciprocal insurers shall be subject to and governed by the other applicable provisions of this Code.

C. Existing authorized reciprocal insurers shall after the effective date of this Code comply with the provisions of this article, and shall make such amendments to their subscribers' agreement, power of attorney, policies and other documents and accounts and perform such other acts as may be required for such compliance.

Laws 1957, p. 354, § 2903.

§36-2904. Insuring powers of reciprocals.

A. A reciprocal insurer may, upon qualifying therefor as provided for by this Code, transact any kind or kinds of insurance defined by this Code, other than life or title insurance.

B. Such an insurer may purchase reinsurance upon the risk of any subscriber, and may grant reinsurance as to any kind of insurance it is authorized to transact direct.

Laws 1957, p. 355, § 2904.

§36-2905. Name; suits.

A reciprocal insurer shall:

1. Have and use a business name. The name shall include the word "reciprocal," or "interinsurer," or "inter-insurance," or "exchange," or "underwriters," or "underwriting."
2. Sue and be sued in its own name.

Laws 1957, p. 355, § 2905.

§36-2906. Attorney.

A. "Attorney," as used in this article refers to the attorney-in-fact of a reciprocal insurer. The attorney may be an individual, firm, or corporation.

B. The attorney of a foreign or alien reciprocal insurer, which insurer is duly authorized to transact insurance in this state, shall not, by virtue of discharge of its duties as such attorney with respect to the insurer's transactions in this state, be thereby deemed to be doing business in this state within the meaning of any laws of this state applying to foreign firms or corporations.

Added by Laws 1957, p. 355, § 2906, operative July 1, 1957.

§36-2907. Surplus funds required.

A. A domestic reciprocal insurer hereunder formed, if it has otherwise complied with the provisions of this Code, may be authorized to transact insurance if it deposits and maintains on deposit with the State Treasurer, through the office of the Insurance Commissioner, surplus funds as follows:

1. To transact property insurance, surplus funds of not less than One Hundred Thousand Dollars (\$100,000.00).
2. To transact vehicle insurance, surplus funds of not less than One Hundred Fifty Thousand Dollars (\$150,000.00).

B. A domestic reciprocal insurer may be authorized to transact additional kinds of insurance if it has otherwise complied with the provisions of this Code therefor and possesses and so maintains on deposit surplus funds in amount equal to the minimum capital required of a stock insurer for authority to transact a like combination of kinds of insurance.

Laws 1957, p. 355, § 2907.

§36-2908. Organization of reciprocal insurer.

A. Two or more persons domiciled in Oklahoma may organize a domestic reciprocal insurer and make application to the Insurance Commissioner for a certificate of authority to transact insurance.

B. The proposed attorney shall fulfill the requirements of and shall execute and file with the Insurance Commissioner, when

applying for a certificate of authority, a declaration setting forth:

1. The name of the insurer;
2. The location of the insurer's principal office, which shall be the same as that of the attorney and shall be maintained within this state;
3. The kinds of insurance proposed to be transacted;
4. The names and addresses of the original subscribers;
5. The designation and appointment of the proposed attorney and a copy of the power of attorney;
6. The names and addresses of the officers and directors of the attorney, if a corporation, or its members, if a firm;
7. The powers of the subscribers' advisory committee, and the names and terms of office of the members thereof;
8. That all monies paid to the reciprocal shall, after deducting therefrom any sum payable to the attorney, be held in the name of the insurer and for the purposes specified in the subscribers' agreement;
9. A copy of the subscribers' agreement;
10. A statement that each of the original subscribers has in good faith applied for insurance of a kind proposed to be transacted, and that the insurer has received from each such subscriber the full premium or premium deposit required for the policy applied for, for a term of not less than six (6) months at an adequate rate theretofore filed with and approved by the Insurance Commissioner;
11. A statement of the financial condition of the insurer, a schedule of its assets, and a statement that the surplus as required by Section 2907 of this article is on hand; and
12. A copy of each policy, endorsement, and application form it then proposes to issue or use.

Such declaration shall be acknowledged by the attorney in the manner required for the acknowledgement of deeds.

Added by Laws 1957, p. 355, § 2908, operative July 1, 1957. Amended by Laws 2006, c. 264, § 59, eff. July 1, 2006.

§36-2909. Certificate of authority.

A. The certificate of authority of a reciprocal insurer shall be issued to its attorney in the name of the insurer.

B. The Insurance Commissioner may refuse, suspend, or revoke the certificate of authority, in addition to other grounds therefor, for failure to comply with any provision of this Code.

Laws 1957, p. 356, § 2909.

§36-2910. Power of attorney.

A. The rights and powers of the attorney of a reciprocal insurer shall be as provided in the power of attorney given it by the subscribers.

B. The power of attorney must set forth:

1. The powers of the attorney;

2. That the attorney is empowered to accept service of process on behalf of the insurer and to authorize the Insurance Commissioner to receive service of process in actions against the insurer upon contracts exchanged;

3. The general services to be performed by the attorney;

4. The maximum amount to be deducted from advance premiums or deposits to be paid to the attorney and the general items of expense in addition to losses, to be paid by the insurer;

5. Except as to nonassessable policies, a provision for a contingent several liability of each subscriber in a specified amount which amount shall be not less than one nor more than ten times the premium or premium deposit stated in the policy.

C. The power of attorney may:

1. Provide for the right of substitution of the attorney and revocation of the power of attorney and rights thereunder;

2. Impose such restrictions upon the exercise of the power as are agreed upon by the subscribers;

3. Provide for the exercise of any right reserved to the subscribers directly or through their advisory committee;

4. Contain other lawful provisions deemed advisable.

D. The terms of any power of attorney or agreement collateral thereto shall be reasonable and equitable, and no such power or agreement shall be used or be effective in Oklahoma until approved by the Insurance Commissioner.

Laws 1957, p. 356, § 2910.

§36-2911. Modifications.

Modification of the terms of the subscribers' agreement or of the power of attorney of a domestic reciprocal insurer shall be made jointly by the attorney and the subscribers' advisory committee. No such modification shall be effective retroactively, nor as to any insurance contract issued prior thereto.

Laws 1957, p. 356, § 2911.

§36-2912. Attorney's bond.

A. Concurrently with the filing of the declaration provided for in Section 2908 of this article, the attorney of a domestic reciprocal insurer shall file with the Insurance Commissioner a bond in favor of the State of Oklahoma for the benefit of all persons damaged as a result of breach by the attorney of the conditions of his bond as set forth in subsection B hereof. The bond shall be

executed by the attorney and by an authorized corporate surety, and shall be subject to the Insurance Commissioner's approval.

B. The bond shall be in the penal sum of Twenty-five Thousand Dollars (\$25,000.00), aggregate in form, conditioned that the attorney will faithfully account for all monies and other property of the insurer coming into his hands, and that he will not withdraw or appropriate to his own use, from the funds of the insurer, any monies or property to which he is not entitled under the power of attorney.

C. The bond shall provide that it is not subject to cancellation unless thirty (30) days' advance notice in writing of cancellation is given both the attorney and the Insurance Commissioner.

Laws 1957, p. 357, § 2912.

§36-2913. Deposit in lieu of bond.

In lieu of such bond, the attorney may maintain on deposit with the State Treasurer through the office of the Insurance Commissioner a like amount in cash or in value of securities qualified under this Code as insurers' investments, and subject to the same conditions as the bond.

Laws 1957, p. 357, § 2913.

§36-2914. Action on bond.

Action on the attorney's bond or to recover against any such deposit made in lieu thereof may be brought at any time by one or more subscribers suffering loss through a violation of its conditions, or by a receiver or liquidator of the insurer. Amounts recovered on the bond shall be deposited in and become part of the insurer's funds. The total aggregate liability of the surety shall be limited to the amount of the penalty of such bond.

Laws 1957, p. 357, § 2914.

§36-2915. Legal process service - Judgment.

A. Legal process shall be served upon a domestic reciprocal insurer by serving the insurer's attorney at his principal offices.

B. Any judgment based upon legal process so properly served shall be binding upon each of the insurer's subscribers as their respective interests may appear but in an amount not exceeding their respective contingent liabilities, if any, the same as though personal service of process was had upon each such subscriber.

Added by Laws 1957, p. 357, § 2915, operative July 1, 1957.

§36-2916. Annual statement.

A. The annual statement of a reciprocal insurer shall be made and filed by its attorney.

B. The statement shall be supplemented by such information as may be required by the Insurance Commissioner relative to the affairs and transactions of the attorney.
Laws 1957, p. 357, § 2916.

§36-2917. Contributions to insurer.

The attorney or other parties may advance to a domestic reciprocal insurer upon reasonable terms such funds as it may require from time to time in its operations. Sums so advanced shall not be treated as a liability of the insurer, and, except upon liquidation of the insurer, shall not be withdrawn or repaid except out of the insurer's realized earned surplus in excess of its minimum required surplus. No such withdrawal or repayment shall be made without the advance approval of the Insurance Commissioner.
Added by Laws 1957, p. 357, § 2917, operative July 1, 1957.

§36-2918. Financial conditions; method of determining.

In determining the financial condition of a reciprocal insurer the Insurance Commissioner shall apply the following rules:

1. The Commissioner shall charge as liabilities the same reserves as are required of incorporated insurers issuing nonassessable policies on a reserve basis.

2. The surplus deposits of subscribers shall be allowed as assets, except that any premium deposit delinquent for ninety (90) days shall first be charged against such surplus deposit.

3. The surplus deposits of subscribers shall not be charged as a liability.

4. All premium deposits delinquent less than ninety (90) days shall be allowed as assets.

5. An assessment levied upon subscribers, and not collected, shall not be allowed as an asset.

6. The contingent liability of subscribers shall not be allowed as an asset.

7. The computation of reserves shall be based upon premium deposits other than membership fees and without any deduction for the compensation of the attorney.

Laws 1957, p. 357, § 2918.

§36-2919. Who may be subscribers.

Individuals, partnerships, and corporations of this state may make application, enter into agreement for and hold policies or contracts in or with and be a subscriber of any domestic, foreign, or alien reciprocal insurer. Any corporation now or hereafter organized under the laws of this state shall, in addition to the rights, powers, and franchises specified in its articles of incorporation, have full power and authority as a subscriber to exchange insurance contracts through such reciprocal insurance. The

right to exchange such contracts is hereby declared to be incidental to the purposes for which such corporations are organized and to be fully granted as the rights and powers expressly conferred upon such corporations. Government or governmental agencies, state or political subdivisions thereof, boards, associations, estates, trustees or fiduciaries are authorized to exchange nonassessable reciprocal inter-insurance contracts with each other and with individuals, partnerships, and corporations to the same extent that individuals, partnerships and corporations are herein authorized to exchange reciprocal inter-insurance contracts. Any officer, representative, trustee, receiver, or legal representative of any such subscriber shall be recognized as acting for or on its behalf for the purpose of such contract but shall not be personally liable upon such contract by reason of acting in such representative capacity.

Laws 1957, p. 358, § 2919.

§36-2920. Subscribers' advisory committee.

A. The advisory committee of a domestic reciprocal insurer exercising the subscribers' rights shall be selected under such rules as the subscribers adopt.

B. Not less than two-thirds (2/3) of such committee shall be subscribers other than the attorney, or any person employed by, representing, or having a financial interest in the attorney.

C. The committee shall:

1. Supervise the finances of the insurer;

2. Supervise the insurer's operations to such extent as to assure conformity with the subscribers' agreement and power of attorney;

3. Procure the audit of the accounts and records of the insurer and of the attorney at the expense of the insurer;

4. Have such additional powers and functions as may be conferred by the subscribers' agreement.

Laws 1957, p. 358, § 2920.

§36-2921. Subscriber's liability.

A. The liability of each subscriber, other than as to a nonassessable policy, for the obligations of the reciprocal insurer shall be an individual, several, and proportionate liability, and not joint.

B. Except as to a nonassessable policy each subscriber shall have a contingent assessment liability, in the amount provided for in the power of attorney or in the subscribers' agreement, for payment of actual losses and expenses incurred while his policy was in force. Such contingent liability may be at the rate of not less than one nor more than ten times the premium or premium deposit

stated in the policy, and the maximum aggregate thereof shall be computed in the manner set forth in section 2925 of this article.

C. Each assessable policy issued by the insurer shall contain a statement of the contingent liability, set in type of the same prominence as the insuring clause.

Laws 1957, p. 358, § 2921.

§36-2922. Subscriber's liability on judgments.

A. No action shall lie against any subscriber upon any obligation claimed against the insurer until a final judgment has been obtained against the insurer and remains unsatisfied for thirty (30) days.

B. Any such judgment shall be binding upon each subscriber only in such proportion as his interests may appear and in amount not exceeding his contingent liability, if any.

Laws 1957, p. 359, § 2922.

§36-2926. Nonassessable policies.

A. If a reciprocal insurer has a surplus of assets over all liabilities at least equal to the minimum capital stock generally required of a domestic stock insurer authorized to transact like kinds of insurance, upon application of the attorney and as approved by the subscribers' advisory committee the Insurance Commissioner shall issue his certificate authorizing the insurer to extinguish the contingent liability of subscribers under its policies then in force in this state, and to omit provisions imposing contingent liability in all policies delivered or issued for delivery in this state for so long as all such surplus remains unimpaired.

B. Upon impairment of such surplus, the Insurance Commissioner shall forthwith revoke the certificate. Such revocation shall not render subject to contingent liability any policy then in force and for the remainder of the period for which the premium has theretofore been paid; but after such revocation no policy shall be issued or renewed without providing for contingent assessment liability of the subscriber.

C. No insured member or subscriber of a domestic reciprocal insurer shall be liable for assessments on policies issued by such insurer. No policies shall be issued or renewed by a domestic reciprocal insurer which contain provisions for contingent or assessment liability of an insured, member or subscriber. Except, that if required by the laws of another state in which the insurer is transacting insurance as an authorized insurer, the insurer may issue policies providing for the contingent liability of such of its subscribers as may require such policies in such state, and need not extinguish the contingent liability applicable to policies theretofore in force in such state.

Laws 1957, p. 359, § 2926; Laws 1981, c. 112, § 3.

§36-2927. Distribution of savings.

A reciprocal insurer may from time to time return to its subscribers any unused premiums, savings, or credits accruing to their accounts. Any such distribution shall not unfairly discriminate between classes of risks, or policies, or between subscribers, but such distribution may vary as to classes of subscribers based on the experience of such subscribers.
Laws 1957, p. 360, § 2927.

§36-2928. Subscriber's share in assets.

Upon the liquidation of a domestic reciprocal insurer, its assets remaining after discharge of its indebtedness and policy obligations, the return of any contributions of the attorney or other persons to its surplus made as provided in Section 2917 of this article, and the return of any unused premium, savings, or credits then standing on subscribers' accounts, shall be distributed to its subscribers who were such within the twelve (12) months prior to the last termination of its certificate of authority, according to such reasonable formula as the Insurance Commissioner may approve.
Laws 1957, p. 360, § 2928.

§36-2929. Merger or conversion.

A. A domestic reciprocal insurer upon affirmative vote of not less than two-thirds (2/3) of its subscribers who vote on such merger pursuant to due notice and the approval of the Insurance Commissioner of the terms therefor, may merge with another reciprocal insurer or be converted to a stock or mutual insurer.

B. Such a stock or mutual insurer shall be subject to the same capital requirements and shall have the same rights as a like domestic insurer transacting like kinds of insurance.

C. The Insurance Commissioner shall not approve any plans for such merger or conversion which is inequitable to subscribers, or which, if for conversion to a stock insurer, does not give each subscriber preferential right to acquire stock of the proposed insurer proportionate to his interest in the reciprocal insurer as determined in accordance with Section 2928 of this article and a reasonable length of time within which to exercise such right.
Laws 1957, p. 360, § 2929.

§36-2930. Impaired reciprocals.

A. If the assets of a reciprocal insurer are at any time insufficient to discharge its liabilities, other than any liability on account of funds contributed by the attorney or others and to maintain the required surplus, its attorney shall forthwith make up the deficiency or levy an assessment upon the subscribers for the

amount needed to make up the deficiency; but subject to the limitations set forth in the power of attorney or policy.

B. If the attorney fails to make up such deficiency or to make the assessment within thirty (30) days after the Insurance Commissioner orders him to do so, or if the deficiency is not fully made up within sixty (60) days after the date the assessment was made, the insurer shall be deemed insolvent and shall be proceeded against as authorized by this Code.

C. If liquidation of such an insurer is ordered, an assessment shall be levied upon the subscribers for such an amount, subject to limits as provided by this article, as the Insurance Commissioner determines to be necessary to discharge all liabilities of the insurer, exclusive of any funds contributed by the attorney or other persons, but including the reasonable cost of the liquidation. Laws 1957, p. 360, § 2930.

§36-2931. Real estate transactions - Restrictions.

A reciprocal insurer, as defined in Section 2902 of Title 36 of the Oklahoma Statutes, may purchase, receive, own, hold, lease, mortgage, pledge, or encumber, by deed of trust or otherwise, manage, or sell real property in its own name for the purposes and objects of such insurer, pursuant to the provisions of Section 1624 of Title 36 of the Oklahoma Statutes. Any contract, deed, lease, mortgage, deed of trust, purchase or sale agreement, or any other contract, document or instrument to be executed in the name of the reciprocal insurer may be executed by the attorney-in-fact for the insurer, as defined in Section 2906 of Title 36 of the Oklahoma Statutes. This provision shall apply to any contract, deed, lease, mortgage, deed of trust, purchase or sale agreement, or any other contract, document or instrument made and entered into by any reciprocal insurer on and after September 1, 1990.

A reciprocal insurer doing business in this state shall be subject to the same restrictions pertaining to ownership of real property and other real estate transactions that exist for corporations pursuant to Section 2 of Article XXII of the Oklahoma Constitution.

Added by Laws 1990, c. 3, § 1, emerg. eff. March 29, 1990.

§36-3001. Underwriters; forms of insurance authorized, articles of agreements.

"Underwriters" Defined. Individuals, partnerships, or associations of individuals, hereby designated "underwriters," are authorized to make any insurance as hereinafter provided, except life insurance or title insurance, on the Lloyd's plan, by executing articles of agreement expressing their purpose so to do, and complying with the requirements set forth in this article. Laws 1957, p. 360, § 3001.

§36-3002. Attorneys; office. - "Attorneys" defined.

Policies of insurance may be executed by an attorney or by an attorney-in-fact, or other representative, hereby designated "attorney," authorized by and acting for such underwriters under power of attorney. The principal office of such attorneys shall be maintained at such place as may be designated by the underwriters in their articles of agreement; provided, that no license shall be issued to any attorney at Lloyd's to bind risks or insurance in Oklahoma, or with citizens of Oklahoma, or covering property in Oklahoma, unless their attorneys-in-fact be residents of this state and maintain their offices in this state, except as may be hereinafter specifically provided.

Laws 1957, p. 361, § 3002.

§36-3003. Application for license; contents; kinds of insurance authorized; financial statement; process.

The attorney shall file with the Insurance Commissioner a verified application for license setting forth and accompanied by:

1. The name of the attorney or attorneys and the title under which the business is to be conducted, which title shall contain the name Lloyds, and shall not be so similar to any name or title in use in this state as to be likely to confuse or deceive.

2. The location of the principal office.

3. The kind or combination of kinds of insurance to be written, as defined in Article 7, (Kinds of Insurance; Reinsurance; Limits of Risk) of this Code.

4. A copy of the form of power of attorney by virtue of which the attorney is to act for and bind the several underwriters, and a copy of the articles of agreement entered into between the underwriters themselves and the attorney.

5. The names and addresses of all underwriters, whose number shall not be less than three.

6. A financial statement showing in detail the assets contributed or accumulated in the hands of the attorneys-in-fact, committee of underwriters, trustees, or other officers of such underwriters at Lloyd's, together with the liabilities incurred and outstanding and the income received and disbursements made by the attorney for the underwriters.

7. An instrument executed by each and all of the underwriters specially empowering the attorney to accept service of process for each underwriter in any action on any policy or contract of insurance, and an instrument from the attorney to the Insurance Commissioner delegating the attorney's powers in this respect to such Insurance Commissioner.

Laws 1957, p. 361, § 3003.

§36-3004. Accounts for each kind of insurance.

In the accounts pertaining to each kind of insurance shall be entered all receipts thereof and all expenses incurred directly in its behalf and due proportion of the unallocated expenses of the Lloyd's in such manner as to show separately the underwriting experience.

Laws 1957, p. 361, § 3004.

§36-3005. Assets required as condition precedent.

No attorney shall be licensed for the underwriters at a Lloyd's under this Code unless the net assets, including the guaranty fund contributed to the attorney, a committee of underwriters, trustees, or other officers as provided for in the articles of agreement, shall be at least Two Hundred Thousand Dollars (\$200,000.00) in cash, or other admitted assets.

Laws 1957, p. 361, § 3005.

§36-3006. Reserves for liabilities and losses.

Underwriters at a Lloyd's are required to compute reserve liabilities for all outstanding business and for all incurred losses upon the same basis required for stock insurance companies doing the same class and character of business in Oklahoma.

Laws 1957, p. 361, § 3006.

§36-3007. Liability of underwriters; limitation.

An underwriter at a Lloyd's may limit his total liability on all risks to the amount of his subscription as expressed in his power of attorney and agreement with the attorney-in-fact; provided at least half of the subscription of each underwriter must be paid or contributed to the guaranty fund in cash or admissible securities. Each underwriter shall be responsible solely for his own liability as fixed in the contract of insurance and shall not be liable as a partner and in no event shall the liability of an underwriter exceed the amount of his total underwriters agreement executed in favor of his respective successor attorney or attorneys-in-fact.

Laws 1957, p. 361, § 3007.

§36-3008. Liability of additional or substituted underwriters; authority of deputy, substitute or successor attorney.

Additional or substituted underwriters shall be bound in the same manner and to the same extent as original subscribers to the articles of agreement and power of attorney on file with the Insurance Commissioner; and the acts of the duly-appointed deputy, substitute or successor attorney or any attorney or attorneys licensed under this chapter, accepting powers of attorney from underwriters, and in making and issuing policies and contracts of insurance, and in doing any additional acts incident thereto, shall

be deemed authorized by the license issued to the original attorney or attorneys.

Laws 1957, p. 364, § 3608.

§36-3009. Division of profits.

No profits shall accrue to an underwriter, except upon the basis of his actual investment in cash or securities, disregarding any obligation or subscription to pay in additional cash or securities at a later date.

Laws 1957, p. 362, § 3009.

§36-3010. Actions on policies or insurance contracts - Process - Judgment - Costs.

Action on any policy or contract of insurance issued by an attorney for the underwriters may be brought against the attorney. In such action, summons and process shall be served on either the Insurance Commissioner or on the attorney-in-fact, and when so served shall have the same effect as if served on the attorney and on each underwriter personally. A judgment in any such action against the attorney shall be binding upon and be judgment against each and all of the underwriters as their several liabilities may appear in the contract of insurance on which the action is brought.

And such summons or other process shall be served in triplicate, and the Insurance Commissioner shall forthwith, by registered mail, send one copy thereof to the attorney for the underwriters at the principal office designated in the application for license or latest amendment thereof. The party commencing any action against the underwriters at a Lloyd's and securing service of process in this manner shall at the time of such service pay to such Insurance Commissioner a fee of Three Dollars (\$3.00), which the party shall be entitled to collect as taxable costs in the action if he shall prevail.

Added by Laws 1957, p. 362, § 3010, operative July 1, 1957. Amended by Laws 2009, c. 432, § 18, eff. July 1, 2009.

§36-3011. Deposit required of foreign Lloyd's in home state as condition to permit.

In case underwriters at a Lloyd's who are nonresidents of Oklahoma, or who maintain their principal office outside of Oklahoma, apply to the Insurance Commissioner for a permit to do business in Oklahoma, such permit shall not be granted unless such underwriters have on deposit with the Insurance Commissioner of their home states net assets in the amount of at least Two Hundred Thousand Dollars (\$200,000.00).

Laws 1957, p. 362, § 3011.

§36-3012. Revocation of license.

If any attorney-in-fact or underwriters at Lloyd's shall violate any of the provisions of this Code, or any of the other laws of the State of Oklahoma which are applicable to them, the license of such attorney shall be revoked and the right to do business in Oklahoma shall be canceled.

Laws 1957, p. 362, § 3012.

§36-3013. Laws applicable to Lloyd's.

A. The provisions of this article are applicable to domestic Lloyd's insurers and to foreign Lloyd's insurers.

B. To the extent not modified by the provisions of this article, Lloyd's insurers shall be subject to and governed by the other applicable provisions of this Code.

Laws 1957, p. 362, § 3013.

§36-3101. Definitions.

As used in this act:

1. "Commissioner" means the Commissioner of Insurance, his or her assistants or deputies, or other persons authorized to act for him or her;

2. "Company" means any person, firm, copartnership, company, association or corporation engaged in selling, furnishing or procuring, either as principal or producer, for a consideration, motor club service;

3. "Producer" means an insurance producer or a limited lines producer who solicits the purchase of service contracts or transmits for another any such contract, or application therefor, to or from the company, or acts or aids in any manner in the delivery or negotiation of any such contract, or in the renewal or continuance thereof. This, however, shall not include any person performing only work of a clerical nature in the office of the motor club;

4. "Towing service" means any act by a company which consists of towing or moving a motor vehicle from one place to another under other than its own power;

5. "Emergency road service" means any act by a company to adjust, repair or replace the equipment, tires or mechanical parts of a motor vehicle so it may operate under its own power; or reimbursement of expenses incurred by a member when his or her motor vehicle is unable to operate under its own power;

6. "Insurance service" means any act to sell or give to the holder of a service contract or as a result of membership in or affiliation with a company a policy of insurance covering the holder for liability or loss for personal injury or property damage resulting from the ownership, maintenance, operation or use of a motor vehicle;

7. "Bail bond service" means any act by a company to furnish or procure a cash deposit, bond or other undertaking required by law

for any person accused of a law violation of this state, pending trial;

8. "Discount service" means any act by a company resulting in special discounts, rebates or reductions of price on gasoline, oil, repairs, insurance, parts, accessories or service for motor vehicles to holders of service contracts;

9. "Financial service" means any act by a company to loan or otherwise advance monies, with or without security, to a service contract holder;

10. "Buying and selling service" means any act by a company to aid the holder of a service contract in the purchase or sale of an automobile;

11. "Theft service" means any act by a company to locate, identify or recover a stolen or missing motor vehicle owned or controlled by the holder of a service contract or to detect or apprehend the person guilty of such theft;

12. "Map service" means any act by a company to furnish road maps without cost to holders of service contracts;

13. "Touring service" means any act by a company to furnish touring information without cost to holders of service contracts;

14. "Legal service" means any act by a company to furnish to a service contract holder, without cost, the services of an attorney;

15. "Motor service club" means the rendering, furnishing or procuring of, or reimbursement for three or more of the following: towing service, emergency road service, insurance service, bail bond service, legal service, discount service, financial service, buying and selling service, theft service, map service, and touring service to any person, in connection with the ownership, operation, use, or maintenance of a motor vehicle by such person, that has membership, for consideration; and

16. "Service contract" means any written agreement whereby any company, for a consideration, promises to render, furnish or procure for any person motor club service.

Added by Laws 1973, c. 127, § 1, emerg. eff. May 9, 1973. Amended by Laws 1987, c. 175, § 23, eff. Nov. 1, 1987; Laws 2021, c. 478, § 18, emerg. eff. May 12, 2021; Laws 2022, c. 154, § 2, eff. Nov. 1, 2022.

§36-3102. Deposit of security prior to doing business - Qualifications - Issuance of certificates - Expiration date.

A. No company shall sell, or offer for sale, any motor club service without first having deposited with the Commissioner the sum of Fifty Thousand Dollars (\$50,000.00), in cash or securities approved by the Commissioner, or, in lieu thereof, a corporate surety bond, approved by the Commissioner, in the form described by the Commissioner, payable to the State of Oklahoma, in the sum of One Hundred Thousand Dollars (\$100,000.00), and conditioned upon the faithful performance in the sale or rendering of motor club service

and payment of any fines or penalties levied against it for failure to comply with the provisions of Section 3101 et seq. of this title. Provided, however, that the aggregate liability of the surety for all breaches of the conditions of the bond and for the payment of all fines and penalties shall, in no event, exceed the amount of the bond.

B. No Certificate of Authority shall be issued by the Commissioner until the company has filed with him the following:

1. A formal application for the certificate in such form and detail as the Commissioner requires, executed under oath by its president or another principal officer of the company;

2. A certified copy of its charter or articles of incorporation and its bylaws, if any;

3. A certificate from the Secretary of State, State of Oklahoma, in the event that it is a domestic corporation, signifying that the company is in compliance with the corporation laws of the State of Oklahoma;

4. A copy of its latest financial statement, or report of independent audit, as the Commissioner may require; or, in the event that neither is available, its most recent audited and certified operating statement and balance sheet. Any such certified operating statement, audit or audited and certified operating statement and balance sheet shall be verified by the person compiling or making the same and by an executive officer of the applicant;

5. A certificate from its domiciliary state regulatory authority, in the event that it is a foreign corporation, to be executed not more than thirty (30) days before the filing of its application, signifying that it is duly authorized to do motor club business in that state;

6. An explanation of its plan of doing business and copies of the following:

a. its application for membership,

b. the proposed membership certificate or identification card and any proposed addendum thereto,

c. any individual insurance policy and any group master policy and individual certificates thereunder to be offered, and

d. any service contract to be issued; and

7. Such other information as the Commissioner may find necessary in order to determine the applicant's qualifications.

C. No Certificate of Authority shall be issued by the Commissioner until the company has:

1. Paid an initial filing fee of Two Hundred Fifty Dollars (\$250.00) to the State Insurance Commissioner Revolving Fund, pursuant to Section 307.3 of this title;

2. Paid an annual license fee of One Hundred Dollars (\$100.00) to the State Insurance Commissioner Revolving Fund, pursuant to Section 307.3 of this title;

3. Had its name approved by the Commissioner under the provisions of Sections 620 and 2104 of this title, the provisions of which are hereby made applicable to motor clubs, after electronic submission of its name request on a form prescribed by the Commissioner;

4. Proved by affidavits of its officers, directors, managers and individual owners of more than ten percent (10%), on a form prescribed by the Commissioner, that it is not disqualified under any provisions contained in Section 3101 et seq. of this title or contained in the Insurance Code; and

5. Proved to the Commissioner's satisfaction that it is a separate legal entity capable of being examined by the Commissioner as provided in Section 3101 et seq. of this title.

D. Certificates of Authority issued hereunder shall expire annually on July 1, unless sooner revoked or suspended, as hereinafter provided.

Added by Laws 1973, c. 127, § 2, emerg. eff. May 9, 1973. Amended by Laws 2018, c. 95, § 6, eff. Nov. 1, 2018.

§36-3103. Revocation or suspension of Certificate of Authority.

The Commissioner may, at any time, for good cause shown and after notice and a public hearing, suspend, revoke or refuse to renew any company's Certificate of Authority, if he finds that any one or more of the following causes or circumstances exist:

1. Any violation of, or noncompliance with, any provision of this act;

2. Obtaining, or attempting to obtain, any Certificate of Authority through misrepresentation or fraud;

3. Fraudulent or dishonest practices;

4. Oral or written misrepresentation of the terms, benefits or privileges of any service contract issued, or to be issued, by it or any other company;

5. Insolvency;

6. Willful solicitation of membership from an individual who is or has been a member of another motor service club by giving said person credit for his years of membership with the other motor service club;

7. Waiving the enrollment fee or otherwise reducing the usual fees and charges for a new member when soliciting membership from an individual who is or has been a member of another motor service club; or

8. Inability for any reason to qualify for the issuance of a Certificate of Authority as a motor service club.

Laws 1973, c. 127, § 3, emerg. eff. May 9, 1973.

§36-3104. Approval of form of service contract.

A. No service contract shall be executed, issued or delivered in this state until the form thereof has been approved in writing by the Commissioner, and all promotional and advertising material, membership cards and other indicia of membership shall be submitted for approval on the request of the Commissioner.

B. Every service contract executed, issued or delivered in this state shall be made in duplicate, with one copy being kept by the issuing company and the other copy delivered to the purchasing party.

C. No service contract shall be executed, issued or delivered in this state unless it contains the following:

1. The exact corporate or other name of the company;

2. The exact location of its home office and of its usual place of business in this state, giving street number and city;

3. A provision that the contract may be canceled at any time by the club or canceled at any time by the holder, if the club or its agent have violated any of the provisions of Section 3 or Section 5 of this act in soliciting the purchase of such contract from the holder. If the contract is canceled, pursuant to this provision, the holder will, if he has actually paid the consideration, thereupon be entitled to the unused portion of the consideration paid for such contract, calculated on a pro rata basis over the period of the contract, without any deductions.

4. Provisions plainly specifying:

a. the services promised,

b. that the holder will not be required to pay any sum, in addition to the amount specified in the contract, for any services thus specified,

c. the territory wherein such services are to be rendered, and

d. the date when such service will commence.

5. A statement in not less than 14-point modern type at the head of said contract stating, "This is not an insurance contract." Laws 1973, c. 127, § 4, emerg. eff. May 9, 1973.

§36-3105. Appointment of agent - License - Fees.

A. Each motor service club operating in this state pursuant to certificate of authority issued hereunder shall file with the Commissioner, within ten (10) days of the date of employment, a notice of appointment of any insurance producer or limited lines producer, resident or nonresident, appointed by the automobile club to sell memberships in the motor service club to the public. This notification shall be upon such form as the Commissioner may prescribe and shall contain the name, address, age, sex, and Social Security number of such club producer, and shall also contain proof

satisfactory to the Commissioner that such applicant is not less than eighteen (18) years of age, is of good reputation, and has received training from the club or is otherwise qualified in the field of motor service club service contracts and knowledgeable of the laws of this state pertaining thereto.

B. A licensing fee for insurance producers and limited lines producers, resident or nonresident, shall be in accordance with Section 1435.23 of this title.

C. Upon notice and hearing, the Commissioner may suspend, censure, revoke, or refuse to renew any license of a producer if he finds as to the licensee that any one or more of the following causes exist:

1. Any violation of or noncompliance with any provision of this act;

2. Obtaining or attempting to obtain any such license through misrepresentation or fraud;

3. Oral or written misrepresentation of the terms, conditions, benefits, or privileges of any motor service club service contract issued or to be issued by the motor service club he represents or any other motor service club;

4. Misappropriation or conversion to his own use or illegal holding of monies, belonging to members or others, received in the conduct of business under his license;

5. Pleading nolo contendere or guilty to a felony or conviction by final judgment of a felony;

6. Demonstration of incompetence sufficient in the opinion of the Commissioner to make the producer a source of injury and loss to the public;

7. Fraudulent or dishonest practices;

8. Willful solicitation of membership from an individual who is or has been a member of another motor service club by giving said person credit for his years of membership with the other motor service club;

9. Waiving the enrollment fee or otherwise reducing the usual fees and charges for a new member when soliciting membership from an individual who is or has been a member of another motor service club.

D. In addition to the penalties provided for in this section, a fine of not less than One Hundred Dollars (\$100.00) nor more than One Thousand Dollars (\$1,000.00) for each occurrence may be levied. Added by Laws 1973, c. 127, § 5, emerg. eff. May 9, 1973. Amended by Laws 1984, c. 173, § 9, emerg. eff. May 7, 1984; Laws 2009, c. 432, § 19, eff. July 1, 2009; Laws 2021, c. 478, § 19, emerg. eff. May 12, 2021; Laws 2022, c. 154, § 3, eff. Nov. 1, 2022.

§36-3106. Examination of financial condition.

A. Whenever the Insurance Commissioner deems it to be prudent or necessary the Commissioner shall personally, or by an authorized representative, visit each motor service club and thoroughly inspect and examine its financial condition, its ability to fulfill its obligations, whether it has complied with the provisions of this act and any other facts relative to its business methods, management and the equity of its dealings with its members.

B. Every motor service club shall furnish to the Commissioner, on or before July 1 of each year, on blanks prescribed and furnished by the Commissioner, a statement which shall exhibit the financial condition of the company as of December 31 of the previous calendar year. Such statements shall be subscribed and sworn to by the president and secretary or two other proper officers of the company. Added by Laws 1973, c. 127, § 6, emerg. eff. May 9, 1973. Amended by Laws 2002, c. 307, § 26, eff. Nov. 1, 2002.

§36-3107. Solicitation for unlicensed companies prohibited.

No person shall solicit, or aid in the solicitation of, another person to purchase a service contract issued by a company not duly licensed under the terms of this act.

Laws 1973, c. 127, § 7, emerg. eff. May 9, 1973.

§36-3108. Misrepresentation.

A motor service club or an officer or producer thereof shall not in any manner misrepresent the terms, benefits or privileges of any service contract issued or to be issued by it or by another motor service club.

Added by Laws 1973, c. 127, § 8, emerg. eff. May 9, 1973. Amended by Laws 2021, c. 478, § 20, emerg. eff. May 12, 2021.

§36-3109. Contracts issued contrary to act as valid and binding on company.

Any service contract made, issued or delivered contrary to any provision of this act shall nevertheless be valid and binding on the company.

Laws 1973, c. 127, § 9, emerg. eff. May 9, 1973.

§36-3110. Inapplicability to attorneys and insurance, bonding or surety companies.

Nothing in this act shall apply to a duly authorized attorney-at-law acting in the usual cause of his profession nor to any insurance company, bonding company or surety company now or hereafter duly and regularly licensed and doing business as such under the laws of this state.

Laws 1973, c. 127, § 10, emerg. eff. May 9, 1973.

§36-3111. Disposition of fees - Personnel.

All filing fees and examination costs collected under this act shall be credited to the General Fund of the State of Oklahoma. The Commissioner is authorized to employ such personnel as may be necessary to carry out the provisions of this act and to fix their compensation within the amounts made available by appropriation and by the fund established by this section.
Laws 1973, c. 127, § 11, emerg. eff. May 9, 1973.

§36-3112. Penalties.

Any person violating any of the provisions of this act shall be deemed guilty of a misdemeanor and upon conviction thereof shall be punished by a fine of not more than Five Hundred Dollars (\$500.00) or by imprisonment in the county jail for not more than six (6) months, or by both such fine and imprisonment.
Laws 1973, c. 127, § 12, emerg. eff. May 9, 1973.

§36-3201. Short title.

Sections 22 through 24 of this act shall be known and may be cited as the "Oklahoma Child Health Insurance Reform Act".
Added by Laws 1994, c. 294, § 22, eff. Sept. 1, 1994.

§36-3202. Definitions.

As used in the Oklahoma Child Health Insurance Reform Act:

1. "Child health supervision services" means the periodic review of a child's physical and emotional status by a physician or other primary health care provider or pursuant to a physician's supervision;
2. "Review" shall include but not be limited to a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests in keeping with prevailing medical standards;
3. "Health care insurer" means any entity that provides health insurance in this state. For the purposes of the Oklahoma Child Health Insurance Reform Act, insurer includes but is not limited to a licensed insurance company, not-for-profit hospital service or medical indemnity corporation, a fraternal benefit society, a health maintenance organization, a prepaid health plan, a multiple employer welfare arrangement or any other entity providing a plan of health insurance or health benefits subject to state regulation; and
4. "Health benefit plan" means any group hospital or medical policy or certificate, contract of insurance provided by a not-for-profit hospital service or medical indemnity plan, prepaid health plan, or health maintenance organization subscriber contract. Health benefit plan does not include accident-only, credit, dental, vision, Medicare supplement, long-term care, specified disease, hospital indemnity, or disability income insurance, coverage issued as a supplement to liability insurance, workers' compensation or

similar insurance, any plan, or automobile medical payment insurance.

Added by Laws 1994, c. 294, § 23, eff. Sept. 1, 1994.

§36-3203. Coverage for child health supervision services.

A. All health benefit plans which provide coverage for a family member of the insured or subscriber shall offer coverage for child health supervision services. Such services shall include coverage from the moment of birth through the age of eighteen years. Each such plan or contract shall, at a minimum, provide benefits for child health supervision services at approximately the following age intervals: birth, two months, four months, six months, nine months, twelve months, eighteen months, two years, three years, four years, five years, six years, eight years, ten years, twelve years, fourteen years, sixteen years and eighteen years. A health benefit plan may provide that child health supervision services which are rendered during a periodic review shall only be covered to the extent that services are provided by or under the supervision of a single physician or other primary health care provider during the course of one visit. Benefits for such services shall be subject to the same durational limits, dollar limits, deductibles and coinsurance factors as other covered services in such health insurance policies. All Oklahoma health benefit plans delivered, issued for delivery, modified or renewed on or after January 1, 1995, shall be subject to the provisions of this section.

B. Nothing in the Oklahoma Child Health Insurance Reform Act shall prohibit the health care insurer from including any or all coverage for child health supervision services as standard coverage in their policies or contracts.

Added by Laws 1994, c. 294, § 24, eff. Sept. 1, 1994.

§36-3301. Short title - Own Risk and Solvency Assessment (ORSA) Act.

This act shall be known and may be cited as the "Own Risk and Solvency Assessment (ORSA) Act".

Added by Laws 2015, c. 228, § 1, eff. Jan. 1, 2016.

§36-3302. Definitions.

As used in the Own Risk and Solvency Assessment (ORSA) Act:

1. "Insurance group" shall mean, for the purpose of conducting an Own Risk and Solvency Assessment (ORSA), those insurers and affiliates included within an insurance holding company system as defined in Section 1651 of Title 36 of the Oklahoma Statutes;

2. "Insurer" shall have the same meaning as set forth in Section 103 of Title 36 of the Oklahoma Statutes, except that it shall not include agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of

Puerto Rico, the District of Columbia or a state or political subdivision of a state;

3. "Own Risk and Solvency Assessment" or "ORSA" shall mean a confidential internal assessment, appropriate to the nature, scale, and complexity of an insurer or insurance group, conducted by that insurer or insurance group of the material and relevant risks associated with the insurer or insurance group's current business plan, and the sufficiency of capital resources to support those risks;

4. "ORSA Guidance Manual" shall mean the current version of the Own Risk and Solvency Assessment Guidance Manual developed and adopted by the National Association of Insurance Commissioners (NAIC), as amended from time to time. A change in the ORSA Guidance Manual shall be effective on January 1 following the calendar year in which the changes have been adopted by the NAIC; and

5. "ORSA Summary Report" shall mean a confidential high-level summary of an insurer's or insurance group's ORSA.

Added by Laws 2015, c. 228, § 2, eff. Jan. 1, 2016.

§36-3303. Risk management framework.

An insurer shall maintain a risk management framework to assist the insurer with identifying, assessing, monitoring, managing, and reporting on its material and relevant risks. This requirement may be satisfied if the insurance group of which the insurer is a member maintains a risk management framework applicable to the operations of the insurer.

Added by Laws 2015, c. 228, § 3, eff. Jan. 1, 2016.

§36-3304. ORSA - When required.

Subject to the provisions of Section 6 of this act, an insurer, or the insurance group of which the insurer is a member, shall regularly conduct an ORSA consistent with a process comparable to the ORSA Guidance Manual. The ORSA shall be conducted no less than annually, but also at any time when there are significant changes to the risk profile of the insurer or the insurance group of which the insurer is a member.

Added by Laws 2015, c. 228, § 4, eff. Jan. 1, 2016.

§36-3305. ORSA Summary Report.

A. Upon the Insurance Commissioner's request, and no more than once each year, an insurer shall submit to the Insurance Commissioner an ORSA Summary Report or any combination of reports that together contain the information described in the ORSA Guidance Manual, applicable to the insurer and/or the insurance group of which it is a member. Notwithstanding any request from the Insurance Commissioner, if the insurer is a member of an insurance group, the insurer shall submit the report(s) required by this

subsection if the Insurance Commissioner is the lead state Insurance Commissioner of the insurance group as determined by the procedures within the Financial Analysis Handbook adopted by the National Association of Insurance Commissioners.

B. The report(s) shall include a signature of the insurer or insurance group's chief risk officer or other executive having responsibility for the oversight of the insurer's enterprise risk management process attesting to the best of his or her belief and knowledge that the insurer applies the enterprise risk management process described in the ORSA Summary Report and that a copy of the report has been provided to the insurer's board of directors or the appropriate committee thereof.

C. An insurer may comply with subsection A of this section by providing the most recent and substantially similar reports provided by the insurer or another member of an insurance group of which the insurer is a member to the Insurance Commissioner of another state or to a supervisor or regulator of a foreign jurisdiction, if that report provides information that is comparable to the information described in the ORSA Guidance Manual. Any such report in a language other than English must be accompanied by a translation of that report into the English language.

D. The first filing of the ORSA Summary Report shall be in 2016 pursuant to this section.

Added by Laws 2015, c. 228, § 5, eff. Jan 1, 2016.

§36-3306. Exemptions--Waiver.

A. An insurer shall be exempt from the requirements of this act, if:

1. The insurer has annual direct written and unaffiliated assumed premiums, including international direct and assumed premiums, but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, of less than Five Hundred Million Dollars (\$500,000,000.00); and

2. The insurance group of which the insurer is a member has annual direct written and unaffiliated assumed premiums including international direct and assumed premiums, but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, of less than One Billion Dollars (\$1,000,000,000.00).

B. If an insurer qualifies for exemption pursuant to paragraph 1 of subsection A of this section, but the insurance group of which the insurer is a member does not qualify for exemption pursuant to paragraph 2 of subsection A of this section, then the ORSA Summary Report that may be required pursuant to Section 5 of this act shall include every insurer within the insurance group. This requirement may be satisfied by the submission of more than one ORSA Summary Report for any combination of insurers, provided any combination of reports includes every insurer within the insurance group.

C. If an insurer does not qualify for exemption pursuant to paragraph 1 of subsection A of this section, but the insurance group of which it is a member qualifies for exemption pursuant to paragraph 2 of subsection A of this section, then the only ORSA Summary Report that may be required pursuant to the provisions of Section 5 of this act shall be the report applicable to that insurer.

D. An insurer that does not qualify for exemption pursuant to subsection A of this section may apply to the Insurance Commissioner for a waiver from the requirements of this act. In deciding whether to grant the insurer's request for waiver, the Insurance Commissioner may consider the type and volume of business written, ownership and organizational structure, and any other factor the Insurance Commissioner considers relevant to the insurer or insurance group of which the insurer is a member. If the insurer is part of an insurance group with insurers domiciled in more than one state, the Insurance Commissioner shall coordinate with the lead state Insurance Commissioner and with the other domiciliary Insurance Commissioners in considering whether to grant the insurer's request for a waiver.

E. Notwithstanding the exemptions stated in this section:

1. The Insurance Commissioner may require that an insurer maintain a risk management framework, conduct an ORSA and file an ORSA Summary Report based on circumstances including, but not limited to, the type and volume of business written, ownership and organizational structure, federal agency requests, and international supervisor requests; and

2. The Insurance Commissioner may require that an insurer maintain a risk management framework, conduct an ORSA, and file an ORSA Summary Report if the insurer has risk-based capital for a Company Action Level Event as provided by law, meets one or more of the standards of an insurer deemed to be in hazardous financial condition as provided by law or otherwise exhibits qualities of a troubled insurer as determined by the Insurance Commissioner.

F. If an insurer that qualifies for an exemption pursuant to subsection A of this section subsequently no longer qualifies for that exemption due to changes in premium as reflected in the insurer's most recent annual statement or in the most recent annual statements of the insurers within the insurance group of which the insurer is a member, the insurer shall have one (1) year following the year the threshold is exceeded to comply with the requirements of this act.

Added by Laws 2015, c. 228, § 6, eff. Jan. 1, 2016.

§36-3307. ORSA Summary Report--Preparation--Supporting information--Review.

A. The ORSA Summary Report shall be prepared consistent with the ORSA Guidance Manual, subject to the requirements of subsection B of this section. Documentation and supporting information shall be maintained and made available upon examination or upon request of the Insurance Commissioner.

B. The review of the ORSA Summary Report and any additional requests for information shall be made using similar procedures currently used in the analysis and examination of multistate or global insurers and insurance groups.

Added by Laws 2015, c. 228, § 7, eff. Jan. 1, 2016.

§36-3308. Confidentiality and privilege of information--Sharing and receiving information with and from other regulatory agencies.

A. Documents, materials or other information, including the ORSA Summary Report, in the possession of or control of the Department of Insurance that are obtained by, created by or disclosed to the Insurance Commissioner or any other person under this act are recognized by this state as being proprietary and to contain trade secrets. All such documents, materials or other information shall be confidential by law and privileged, shall not be subject to the Oklahoma Open Records Act, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the Insurance Commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the Insurance Commissioner's official duties. The Insurance Commissioner shall not otherwise make the documents, materials or other information public without the prior written consent of the insurer.

B. Neither the Insurance Commissioner nor any person who received documents, materials or other ORSA-related information, through examination or otherwise, while acting under the authority of the Insurance Commissioner or with whom such documents, materials or other information are shared pursuant to this act shall be permitted or required to testify in any private civil action concerning any confidential documents, materials or information subject to subsection A of this section.

C. In order to assist in the performance of the Insurance Commissioner's regulatory duties, the Insurance Commissioner:

1. May, upon request, share documents, materials or other ORSA-related information, including the confidential and privileged documents, materials or information subject to subsection A of this section, including proprietary and trade-secret documents and materials with other state, federal, and international financial regulatory agencies, including members of any supervisory college, with the NAIC and with any third-party consultants designated by the Insurance Commissioner, provided that the recipient agrees in

writing to maintain the confidentiality and privileged status of the ORSA-related documents, materials or other information and has verified in writing the legal authority to maintain confidentiality;

2. May receive documents, materials or other ORSA-related information, including otherwise confidential and privileged documents, materials or information, including proprietary and trade-secret information or documents, from regulatory officials of other foreign or domestic jurisdictions, including members of any supervisory college, and from the NAIC, and shall maintain as confidential or privileged any documents, materials or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

3. Shall enter into a written agreement with the NAIC or a third-party consultant governing sharing and use of information provided pursuant to this act, consistent with this subsection that shall:

- a. specify procedures and protocols regarding the confidentiality and security of information shared with the NAIC or a third-party consultant pursuant to this act, including procedures and protocols for sharing by the NAIC with other state regulators from states in which the insurance group has domiciled insurers. The agreement shall provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the ORSA-related documents, materials or other information and has verified in writing the legal authority to maintain confidentiality,
- b. specify that ownership of information shared with the NAIC or a third-party consultant pursuant to this act remains with the Insurance Commissioner and the NAIC's or a third-party consultant's use of the information is subject to the direction of the Insurance Commissioner,
- c. prohibit the NAIC or third-party consultant from storing the information shared pursuant to this act in a permanent database after the underlying analysis is completed,
- d. require prompt notice to be given to an insurer whose confidential information in the possession of the NAIC or a third-party consultant pursuant to this act is subject to a request or subpoena to the NAIC or a third-party consultant for disclosure or production,
- e. require the NAIC or a third-party consultant to consent to intervention by an insurer in any judicial or administrative action in which the NAIC or a third-

party consultant may be required to disclose confidential information about the insurer shared with the NAIC or a third-party consultant pursuant to this section, and

- f. in the case of an agreement involving a third-party consultant, provide for the insurer's written consent.

D. The sharing of information and documents by the Insurance Commissioner pursuant to this act shall not constitute a delegation of regulatory authority or rulemaking, and the Insurance Commissioner is solely responsible for the administration, execution and enforcement of the provisions of this act.

E. No waiver of any applicable privilege or claim of confidentiality in the documents, proprietary and trade-secret materials or other ORSA-related information shall occur as a result of disclosure of such ORSA-related information or documents to the Insurance Commissioner under this section or as a result of sharing as authorized in this act.

F. Documents, materials or other information in the possession or control of the NAIC or a third-party consultant pursuant to this act shall be confidential by law and privileged, shall not be subject to the Oklahoma Open Records Act, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.

Added by Laws 2015, c. 228, § 8, eff. Jan. 1, 2016.

§36-3309. Penalties.

Any insurer failing, without just cause, to timely file the ORSA Summary Report as required in this act shall be required, after notice and hearing, to pay a penalty of One Thousand Dollars (\$1,000.00) for each day's delay, to be recovered by the Insurance Commissioner. The maximum penalty under this section is Twenty-five Thousand Dollars (\$25,000.00). The Insurance Commissioner may reduce the penalty if the insurer demonstrates to the Insurance Commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.

Added by Laws 2015, c. 228, § 9, eff. Jan. 1, 2016.

§36-3601. Scope of article.

This article shall not apply to:

1. Reinsurance.
2. Policies or contracts not issued for delivery in Oklahoma nor delivered in Oklahoma, except upon subjects of insurance other than life and disability insurance located or to be performed in Oklahoma, and, except as provided in subsection E of Section 3610 of this article.
3. Ocean marine and foreign trade insurances.
4. Title insurance, except as to Section 3617 of this article.

Laws 1957, p. 363, § 3601. 0

§36-3602. "Policy" defined.

"Policy" means contract of or agreement for effecting insurance, or the certificate thereof, by whatever name called, and includes all clauses, riders, endorsements and papers attached thereto and a part thereof.

Laws 1957, p. 363, § 3602.

§36-3603. "Premium" defined.

"Premium" is the consideration for insurance, by whatever name called.

Laws 1957, p. 363, § 3602.

§36-3604. Insurable interest with respect to personal insurance.

A. 1. Any individual of competent legal capacity may procure or effect an insurance contract upon his or her own life or body for the benefit of any person. Except as provided in subsection D of this section, no person shall procure or cause to be procured any insurance contract upon the life or body of another individual unless the benefits under the contract are payable to the individual insured or a personal representatives, or to a person having, at the time when the contract was made, an insurable interest in the individual insured.

2. In the absence of an agreement to the contrary, a policy procured and owned by a corporation, partnership, association, limited liability company, or other legal entity on the life or body of an officer, director, manager, member, or employee, other than a sole proprietor, upon the termination of the insurable interest, the owner of the policy shall, if permitted by the terms of the policy, offer to sell, transfer, or assign the policy to the insured in exchange for the cash surrender value of the policy or, if there is no cash value, in exchange for an amount equal to the total of any premiums paid for the policy, minus any dividends received, plus interest. This offer shall be made in writing to the insured after termination of the insurable interest. The offer shall state the time for acceptance which shall not be less than thirty (30) days after receipt of the offer by the insured. If the insured rejects the offer or fails to accept the offer in the time provided, the owner of the policy may continue to own the policy subject to its terms.

B. If the beneficiary, assignee, or other payee under any contract made in violation of this section receives from the insurer any benefits thereunder accruing upon the death, disability, or injury of the individual insured, the individual insured or an executor or administrator, as the case may be, may maintain an action to recover such benefits from the person receiving them.

C. "Insurable interest" with reference to personal insurance includes only interests as follows:

1. In the case of individuals related closely by blood or by law, a substantial interest engendered by love and affection;

2. In the case of other persons, a lawful and substantial economic interest in having the life, health, or bodily safety of the individual insured continue, as distinguished from an interest which would arise only by, or would be enhanced in value by, the death, disability, or injury of the individual insured;

3. An individual heretofore or hereafter party to a contract or option for the purchase or sale of an interest in a business partnership or firm, or of shares of stock of a closed corporation or of an interest in such shares, has an insurable interest in the life of each individual party to the contract and for the purposes of the contract only, in addition to any insurable interest which may otherwise exist as to the life of the individual;

4. A trustee of a trust, whenever established, shall be deemed to have an insurable interest in:

a. the individual insured who established the trust,

b. each individual in whose life the owner of the trust for federal income tax purposes has an insurable interest, and

c. each individual in whose life a beneficiary of the trust has an insurable interest; and the proceeds of the life insurance policy are primarily for the benefit of the trust beneficiaries having an insurable interest in the life of the individual insured; and

5. a. An employer, or a trust which is sponsored by an employer for the benefit of its employees, shall have an insurable interest in each of the lives of the employees, directors, or retired employees of the employer. Notwithstanding paragraph 2 of subsection C of this section or Section 4101 of this title, and amendments thereto, the employer or trust may insure the life of any employee, director, or retired employee for the benefit of the employer or trust on an individual or group basis only with the written consent of the insured.

b. The consent requirement of Section 3607 of this title shall be accomplished as follows:

(1) the employer shall notify the employee, director, or retired employee by a written notice that the employer or trust would like to obtain life insurance coverage with respect to the person's life, and

(2) if the employee, director, or retired employee fails to provide written consent to the employer

or trust, the employer or trust shall not purchase or obtain such insurance.

- c. It shall be unlawful for the employer or trust to retaliate against any person for refusing to consent to the issuance of insurance on the person.
- d. The insurable interest of the employer or trust in nonmanagement and retired employees shall be limited to an amount agreed to by the employee or, in the absence of an agreement, an amount of aggregate projected death benefits commensurate with the aggregate projected liabilities to the employee under all employee welfare benefit plans, as defined in Section 1002(1) of Title 29 of the United States Code. Calculations of life insurance benefits and welfare benefit liabilities shall be made in accordance with generally accepted actuarial principles. Matching of life insurance benefits and welfare benefit liabilities may be done on cash flow, present value, or other appropriate basis.
- e. For purposes of this section:
 - (1) "employer" means any individual, sole proprietorship, partnership, limited liability company, corporation, or other legal entity that is legally doing business in this state; the term shall also include all entities or persons which are controlled by or affiliated with any of the foregoing. The determination of whether any entity or person is controlled by or affiliated with another shall be made by applying the principles set forth in subsection (b) or (c) of Section 414 of Title 26 of the United States Code, as in effect on January 1, 1993, except that all references therein to eighty percent (80%) shall be changed to fifty-one percent (51%), and
 - (2) "employee" means any common law employee of an employer.
- f. This section shall not be interpreted to limit other insurable interests which may exist by statute or at common law.
- g. Determination of the existence and extent of the insurable interest under any life insurance policy shall be made at the time the contract of insurance becomes effective, provided however, the insurable interest need not exist at the time the loss occurs.

D. Life insurance contracts may be entered into in which the person paying the consideration for the insurance has no insurable

interest in the life of the individual insured, where charitable, benevolent, educational or religious institutions, or their agencies, are designated as the beneficiaries thereof. In no event shall an individual be named as a beneficiary. In making these contracts, the person paying the premium shall make and sign the application therefor as owner and shall designate a charitable, benevolent, educational, or religious institution, or an agency thereof, as the beneficiary or beneficiaries of the contract. The application or any subsequent change of beneficiary designation shall be signed by the individual whose life is to be insured. These contracts shall be valid and binding among the parties, notwithstanding the absence otherwise of an insurable interest in the life of the individual insured.

E. Life insurance contracts may be entered into in which the members of an alumni association of an institution of higher education accredited by the Oklahoma State Regents for Higher Education are insured under a group insurance policy and either the institution is the designated beneficiary thereof or the association is the designated beneficiary with the stipulation that the association will use the proceeds of the policies for direct grants to the institution or for scholarships for students of such institutions. In no event shall an individual be named as a beneficiary to such a policy. In making such contracts, the person paying the premium shall make and sign the application therefor as owner and shall designate an institution or alumni association as the beneficiary or beneficiaries of such contract. The application or any subsequent change of beneficiary designation shall be signed also by the individual whose life is to be insured. These contracts shall be valid and binding among the parties thereto, notwithstanding the absence of an insurable interest in the life of the individual insured.

Added by Laws 1957, p. 363, § 3604. Amended by Laws 1989, c. 320, § 3, eff. Nov. 1, 1989; Laws 1991, c. 223, § 1, emerg. eff. May 23, 1991; Laws 1994, c. 214, § 2, eff. July 1, 1994; Laws 1999, c. 424, § 1, eff. Nov. 1, 1999; Laws 2008, c. 183, § 18, eff. Nov. 1, 2008.

§36-3605. Insurable interest with respect to property insurance.

A. No insurance contract on property or of any interest therein or arising therefrom shall be enforceable as to the insurance except for the benefit of persons having an insurable interest in the things insured.

B. "Insurable interest" as used in this section means any actual, lawful, and substantial economic interest in the safety or preservation of the subject of the insurance free from loss, destruction, or pecuniary damage or impairment.

C. The measure of an insurable interest in property is the extent to which the insured might be damnified by loss, injury, or impairment thereof.

Laws 1957, p. 363, § 3605.

§36-3606. Capacity to contract for insurance; Minors.

A. Any person of competent legal capacity may contract for insurance.

B. A minor not less than fifteen (15) years of age as at nearest birthday may, notwithstanding such minority, contract for life or accident and health insurance on his own life or body or the life or body of any person in whom he has an insurable interest, for his own benefit or for the benefit of his father or mother, spouse, child, brother, sister or grandparents. Such a minor shall, notwithstanding such minority, be deemed competent to exercise all rights and powers with respect to or under any contract of life or accident and health insurance on his own life or body or with respect to or under any contract such minor effected on the life or body of any person in whom he has an insurable interest, as though of full legal age, and may surrender his interest therein and give a valid discharge for any benefit accruing or money payable thereunder. The minor shall not, by reason of his minority, be entitled to rescind, avoid or repudiate the contract, nor to rescind, avoid or repudiate any exercise of a right or privilege thereunder, except that such minor, not otherwise emancipated, shall not be bound by any unperformed agreement to pay, by promissory note or otherwise, any premium on any such insurance contract.

C. A minor not less than sixteen (16) years of age may, notwithstanding such minority, contract for insurance on other subjects of insurance in which he has an insurable interest. A minor shall be bound by any settlement made in connection with any insurance contract so issued. The minor shall not, by reason of his minority, be entitled to rescind, avoid or repudiate the contract, nor to rescind, avoid or repudiate any exercise of a right or privilege thereunder, except that such minor, not otherwise emancipated, shall not be bound by any unperformed agreement to pay, by promissory note or otherwise, any premium on any such insurance contract.

Laws 1957, p. 364, § 3606.

§36-3607. Application required.

No life or accident and health insurance contract upon an individual, except a contract of group life insurance or of group or blanket accident and health insurance, shall be made or effectuated unless at the time of the making of the contract the individual insured, being of competent legal capacity to contract, applies therefor or consents thereto, except in the following cases:

1. A spouse may effectuate such insurance upon the other spouse.

2. Any person having an insurable interest in the life of a minor, or any person upon whom a minor is dependent for support and maintenance, may effectuate insurance upon the life of or pertaining to such minor.

3. Any person having an insurable interest in the life of a person who is legally incompetent to consent to such insurance may effectuate such insurance upon such person.

Laws 1957, p. 364, § 3607.

§36-3608. Application as evidence.

A. No application for the issuance of any life insurance policy or contract shall be admissible in evidence in any action relative to such policy or contract, unless a true copy of the application was attached to or otherwise made a part of the policy when issued. This provision shall not apply to industrial life insurance policies.

B. If any policy of life insurance delivered in this state is reinstated or renewed, and the insured or the beneficiary or assignee of the policy makes written request to the insurer for a copy of the application, if any, for such reinstatement or renewal, the insurer shall, within thirty (30) days after receipt of such request at its home office or at any of its branch offices, deliver or mail to the person making such request a copy of such application. If such copy is not so delivered or mailed after having been so requested, the insurer shall be precluded from introducing the application in evidence in any action or proceeding based upon or involving the policy or its reinstatement or renewal. In the case of such a request from a beneficiary or assignee, the time within which the insurer is required to furnish a copy of such application shall not begin to run until after receipt of evidence satisfactory to the insurer of the beneficiary's or assignee's vested interest in the policy or contract.

C. As to kinds of insurance other than life insurance, no application for insurance signed by or on behalf of the insured shall be admissible in evidence in any action between the insured and the insurer arising out of the policy so applied for, if the insurer has failed, at expiration of thirty (30) days after receipt by the insurer of written demand therefor by or on behalf of the insured, to furnish to the insured a copy of such application reproduced by any legible means.

Laws 1957, p. 364, § 3608.

§36-3609. Representations in applications - Recovery under policy - Mortgage guaranty policies.

A. All statements and descriptions in any application for an insurance policy or in negotiations therefor, by or in behalf of the insured, shall be deemed to be representations and not warranties. Misrepresentations, omissions, concealment of facts, and incorrect statements shall not prevent a recovery under the policy unless:

1. Fraudulent; or
2. Material either to the acceptance of the risk, or to the hazard assumed by the insurer; or
3. The insurer in good faith would either not have issued the policy, or would not have issued a policy in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to the insurer as required either by the application for the policy or otherwise.

B. Subsection A of this section shall not be applicable to mortgage guaranty insurance, as hereinafter defined. Misrepresentations, omissions, concealment of facts and incorrect statements shall not prevent a recovery under a policy of mortgage guaranty insurance unless material and fraudulent. As used herein, the term "mortgage guaranty insurance" means a form of casualty or surety insurance insuring lenders against financial loss by reason of nonpayment of principal, interest and other sums agreed to be paid under the terms of any note, bond or other evidence of indebtedness secured by a mortgage, deed of trust or other instrument constituting a lien or charge on real estate which contains a residential building or a building designed to be occupied for industrial or commercial purposes.
Laws 1957, p. 365, § 3609.

§36-3610. Approval of forms.

A. No insurance policy form or application form, where written application is required and is to be made a part of the policy, rider or endorsement form other than surety bond forms and such other insurance policy forms as are hereinafter specifically otherwise provided for shall be issued, delivered, or used unless filed with and approved by the Insurance Commissioner. This section shall not apply to policies, riders or endorsements of unique character designed for and used with relation to insurance upon a particular subject or which relate to the manner of distribution of benefits or to the reservation of rights and benefits under life or accident and health policies, and are used at the request of the individual policyholder, contract holder, or certificate holder.

B. Every such filing shall be made not less than sixty (60) days in advance of any such delivery. At the expiration of such sixty (60) days the form so filed shall be deemed approved unless prior thereto it has been affirmatively approved or disapproved by order of the Insurance Commissioner. Approval of any such form by

the Commissioner shall constitute a waiver of any unexpired portion of such waiting period. The Insurance Commissioner may extend by not more than an additional thirty (30) days the period within which he may so affirmatively approve or disapprove any such form, by giving notice of such extension before expiration of the initial sixty-day period. At the expiration of any such period as so extended, and in the absence of such prior affirmative approval or disapproval, any such form shall be deemed approved. The Insurance Commissioner may at any time, after notice and for cause shown, withdraw any such approval.

C. Any order of the Insurance Commissioner disapproving any such form or withdrawing a previous approval shall state the grounds therefor.

D. The Insurance Commissioner may, by order, exempt from the requirements of this section for so long as he deems proper any insurance document or form or type thereof as specified in such order, to which, in his discretion this section may not practicably be applied, or the filing and approval of which are, in his opinion, not desirable or necessary for the protection of the public.

E. This section shall apply also to any such form used by domestic insurers for delivery in a jurisdiction outside Oklahoma, if the insurance supervisory official of such jurisdiction informs the Insurance Commissioner that such form is not subject to approval or disapproval by such official, and upon the Commissioner's order requiring the form to be submitted to him for the purpose.
Amended by Laws 1987, c. 210, § 35, eff. July 1, 1987.

§36-3611. Grounds for disapproval of forms - Prevention of delivery of certain policies - Exemptions.

A. The Insurance Commissioner shall disapprove any form of policy, application, rider or endorsement or withdraw any previous approval thereof only:

1. If it is in any respect in violation of or does not comply with this code, including Section 4509 of this title or any other applicable statute in the State of Oklahoma;

2. If it contains or incorporates by reference any inconsistent, ambiguous, or misleading clauses, or exceptions and conditions which deceptively affect the risks purported to be assumed in the general coverage of the contract; and

3. If it has any title, heading, or other indication of its provisions which is misleading.

B. 1. No individual or family accident and health insurance policy, shall be delivered, or issued for delivery, in this state unless:

a. accompanied by an appropriate outline of coverages in plain and simple language, in no less than 10-point type, and provided further, at the top of the front

page of the outline of coverage, in no less than 14-point type, shall state the policy described herein is a limited policy or a substandard policy or other appropriate information, as prescribed by the Insurance Commissioner, and

- b. an appropriate outline of coverage is completed and delivered to the applicant at the time application is made, and an acknowledgment of receipt or certificate of delivery of such outline is provided to the insurer with the application.

In the case of a direct response, such as a written application to the insurance company from an applicant, the outline of coverage shall accompany the policy when issued.

2. Such outline of coverage shall contain:

- a. a statement identifying the applicable category of coverage afforded by the policy as based on the minimum basic standards set forth in the rules and regulations issued to effect compliance with paragraph 3 of this section and Title 36 of the Oklahoma Statutes,
- b. a brief description of the principal benefits and coverage provided in the policy,
- c. a summary statement of the principal exclusions and limitations or reductions contained in the policy, including, but not limited to, pre-existing conditions, probationary periods, elimination periods, and any age limitations or reductions,
- d. a summary statement of the renewal provision, including any reservation of the insurer of a right to change premiums, and
- e. a statement that the outline contains a summary only of the details of the policy as issued or of the policy as applied for and that the issued policy should be referred to for the actual contractual governing provisions.

3. The department shall adopt rules and regulations which establish minimum standards for the general content of forms of individual and family health policies, which shall be inclusive of terms of renewability, initial and subsequent conditions of eligibility, termination of insurance, probationary periods, exclusions, limitations, and reductions. The minimum standards expressed in such rules and regulations shall be in addition to, and in accordance with, individual accident and sickness policy provisions as provided in this title.

4. The department shall adopt rules and regulations which establish minimum standards of benefits and identification for each of the following categories of coverage in individual and family

forms, other than conversion policies, of accident and health insurance:

- a. basic hospital expense insurance,
- b. basic medical expense insurance,
- c. basic surgical expense insurance,
- d. hospital confinement indemnity insurance,
- e. major medical expense insurance,
- f. disability income protection insurance,
- g. accident-only insurance, and
- h. limited benefit insurance.

Nothing in this section shall preclude the issuance of any policy which combines two or more of the categories of coverage enumerated in subparagraphs a through e, or any policy which does not meet the prescribed minimum standards for categories of coverage in subparagraphs a through g when such policy is, in the opinion of the department, either experimental in nature or is demonstrated to be a type of coverage that will fulfill a reasonable need of the person or persons to be insured. Any policy so approved will be identified as to category only as prescribed by the department.

5. The department may, within such time as provided by law for the disapproval of an individual or family form of accident or health insurance, group accident and health insurance, or life and annuity insurance, disapprove any such form if it finds that it does not comply with applicable law in this state or it finds that such form is unjust, unfair, or inequitable to the policyholder, any person insured thereunder, or any beneficiary. In acting upon any such submission, the Commissioner shall, under this section, consider whether the benefits afforded under the submitted policy or benefit form would fulfill a reasonable need of a policyholder. Laws 1957, p. 366, § 3611; Laws 1979, c. 183, § 1, eff. Jan. 1, 1982; Laws 1987, c. 210, § 36, eff. July 1, 1987; Laws 1993, c. 248, § 3, eff. Sept. 1, 1993.

§36-3611.1. Medicare supplement policies - Definitions - Regulations - Issuance - Return and refund - Examination of insurers.

A. As used in this section:

1. "Commissioner" means the Commissioner of Insurance;
2. "Medicare supplement policy" means a group or individual policy of accident and health insurance, or a subscriber contract of a nonprofit hospital service and medical indemnity corporation or a health maintenance organization which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare. Such term does not include:
 - a. a policy or contract of one or more employers or labor organizations, or of the trustees of a fund

established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or combination thereof, or for members or former members, or combination thereof, of the labor organizations, or

- b. a policy or contract of any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association:
 - (1) is composed of individuals all of whom are actively engaged in the same profession, trade or occupation,
 - (2) has been maintained in good faith for purposes other than obtaining insurance, and
 - (3) has been in existence for at least two (2) years prior to the date of its initial offering of such policy or plan to its members, or
- c. individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance; and

3. "Direct response Medicare supplement policy" means a policy of insurance which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare issued as a result of solicitation of individual insureds by mail or by mass media advertising.

B. The Commissioner shall issue reasonable regulations to establish minimum standards for benefit claims payment, marketing practices, compensation arrangements, and reporting practices for Medicare supplement policies. The Commissioner shall issue reasonable regulations to provide for an open enrollment period for those persons who qualify as disabled pursuant to federal Medicare guidelines.

C. A Medicare supplement policy may not deny a claim for losses incurred more than six (6) months from the effective date of coverage for a preexisting condition. The policy may not define a preexisting condition more restrictively than "a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage".

D. Any premium rate filing for a Medicare supplement policy shall be filed with and approved by the Insurance Commissioner and communicated to the policyholder at least forty-five (45) days prior to the effective date of a premium rate increase. Such premium increases shall be implemented no more than once per year.

E. A Medicare supplement policy shall be expected to return to the policyholder benefits which are reasonable in relation to the

premium charged. The Commissioner shall issue regulations to establish minimum standards for loss ratios of Medicare supplement policies on the basis of incurred claims experience, or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis, and earned premiums for the period of coverage for which rates are computed and in accordance with accepted actuarial principles and practices.

F. 1. No Medicare supplement policy or certificate issued pursuant to a group Medicare supplement policy shall be delivered or issued for delivery in this state unless an outline of coverage is provided to the applicant at the time application is made.

2. The Commissioner shall prescribe by regulation the contents and a standard form of an informational brochure for persons eligible for Medicare which is intended to improve the buyer's ability to select the most appropriate coverage and improve the buyer's understanding of Medicare. The Commissioner may require by regulation that the informational brochure be provided with the outline of coverage to any prospective insureds eligible for Medicare. With respect to direct response policies, the Commissioner may require that the prescribed brochure and outline of coverage be provided upon request to any prospective insureds eligible for Medicare, but in no event later than the time of policy delivery.

3. The Commissioner may require notice provisions, designed to inform prospective insureds that particular insurance coverages are not Medicare supplement coverages, for all accident and health insurance policies sold to persons eligible for Medicare by reason of age, other than:

- a. Medicare supplement policies,
- b. disability income policies,
- c. basic, catastrophic, or major medical expense policies,
- d. single premium, nonrenewable policies, or
- e. other policies defined by regulation of the Commissioner.

4. The Commissioner may adopt from time to time, such reasonable regulations as are necessary to conform Medicare supplement policies and certificates to the requirements of federal law and regulations promulgated thereunder, including but not limited to:

- a. requiring refunds or credits if the policies or certificates do not meet loss ratio requirements,
- b. establishing a uniform methodology for calculating and reporting loss ratios,

- c. assuring public access to policies, premiums and loss ratio information of issuers of Medicare supplement insurance, and
- d. establishing a policy for holding public hearings prior to approval of premium increases.

G. Medicare supplement policies or certificates shall have a notice prominently printed on the first page of the policy or certificate, or attached thereto, stating that the applicant shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. A direct response policy issued to persons eligible for Medicare shall have a notice prominently printed on the first page, or attached thereto, stating that the applicant shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination, the applicant is not satisfied for any reason.

H. The Insurance Commissioner shall have the authority to employ actuaries, statisticians, accountants, auditors, investigators, or any other technicians as the Insurance Commissioner may deem necessary or beneficial to examine any Medicare supplement filings made by insurers or rating organizations and to examine such records of the insurers or rating organizations as may be deemed appropriate in conjunction with the Medicare supplement filing in order to determine that the rates or other filings are consistent with the terms, conditions, requirements and purposes of the Insurance Code, and to verify, validate and investigate the information upon which the insurer or rating organization relies to support such filing.

1. The Commissioner shall maintain a list of technicians who are proficient in the line of Medicare supplement insurance. If the Commissioner determines that it is necessary to utilize the services of such a technician, the Commissioner shall employ the next available technician in rotation on the list.

2. All reasonable expenses incurred in such filing review shall be paid by the insurer or rating organization making the filing. Added by Laws 1981, c. 161, § 1, eff. Jan. 1, 1982. Amended by Laws 1989, c. 181, § 8, eff. Nov. 1, 1989; Laws 1991, c. 204, § 13, eff. Sept. 1, 1991; Laws 1992, c. 65, § 4, eff. Sept. 1, 1992; Laws 1993, c. 59, § 1, emerg. eff. April 12, 1993; Laws 1994, c. 129, § 7, eff. Sept. 1, 1994; Laws 2019, c. 135, § 1, eff. July 1, 2019; Laws 2020, c. 48, § 1, eff. Nov. 1, 2020; Laws 2022, c. 142, § 1, eff. Nov. 1, 2022.

§36-3612. Standard provisions.

A. Insurance contracts shall contain such standard provisions as are required by the applicable provisions of this Code pertaining to contracts of particular kinds of insurance. The Insurance Commissioner may waive the required use of a particular standard provision in a particular insurance policy form if:

1. The Commissioner finds such provision unnecessary for the protection of the insured and inconsistent with the purpose of the policy; and

2. The policy is otherwise approved.

B. No policy shall contain any provision inconsistent with or contradictory to any standard provision used or required to be used, but the Insurance Commissioner may approve any substitute provision which is not less favorable in any particular to the insured or beneficiary than the standard provisions or optional standard provisions otherwise required.

C. In lieu of the standard provisions required by the provisions of this Code for contracts for particular kinds of insurance, substantially similar standard provisions required by the law of the domicile of a foreign or alien insurer may be used when approved by the Insurance Commissioner.

D. This section does not apply with respect to the Oklahoma standard fire insurance policy.

Added by Laws 1957, p. 366, § 3612. Amended by Laws 1997, c. 418, § 94, eff. Nov. 1, 1997.

§36-3613. Contents of policies in general.

A. The written instrument in which a contract of insurance is set forth is the policy.

B. Every policy shall specify:

1. The names of the parties to the contract.

2. The insurer's name and complete address.

3. The subject of the insurance.

4. The risks insured against.

5. The time when the insurance thereunder takes effect and the period during which the insurance is to continue.

6. The premium.

7. The conditions pertaining to the insurance.

C. If under the policy the exact amount of premium is determinable only at stated intervals or termination of the contract, a statement of the basis and rates upon which the premium is to be determined and paid shall be included.

D. This section shall not apply to surety contracts, or to group insurance policies.

Laws 1957, p. 366, § 3613.

§36-3613.1. Policies and claims - Fraud warning.

Every insurance policy or application and every insurance claim form shall contain a statement that clearly indicates in substance the following: "WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony." The absence of such a statement shall not constitute a defense in any prosecution. Added by Laws 1993, c. 349, § 31, eff. Sept. 1, 1993. Amended by Laws 2001, c. 363, § 17, eff. July 1, 2001.

§36-3613.2. Restrictions on recording of birth or ultrasound prohibited.

A. No insurer which writes physicians' or hospitals' professional liability insurance shall, in a policy of insurance or in a rider, endorsement, or other amendment of or addition to a policy of insurance or by any means, attempt to restrict, control, or otherwise interfere with any agreement between a patient and a hospital or between a patient and a physician regarding recording of a birth or ultrasound on video tape or disc, or otherwise.

B. The Insurance Commissioner shall revoke or refuse to approve or renew an insurer's certificate of authority for violation of any provision of this subsection.

Added by Laws 1997, c. 156, § 4, eff. Nov. 1, 1997.

§36-3614. Contents of policies; additional contents.

A policy may contain additional provisions not inconsistent with this Code and which are:

1. Required to be inserted by the laws of the insurer's domicile;

2. Necessary, on account of the manner in which the insurer is constituted or operated, in order to state the rights and obligations of the parties to the contract; or

3. Desired by the insurer and neither prohibited by law nor in conflict with any provisions required to be included therein.

Laws 1957, p. 367, § 3614.

§36-3614.1. Genetic nondiscrimination in insurance.

A. This section shall be known and may be cited as the "Genetic Nondiscrimination in Insurance Act".

B. For purposes of the Genetic Nondiscrimination in Insurance Act:

1. "Accident and health insurance" means accident and health insurance as defined in Section 703 of this title, but shall not include disability income or long-term care insurance;

2. "Family member" means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of the individual;

3. "Genetic information" means, with respect to any individual, information about the genetic tests of an individual, the genetic tests of family members of an individual, and the manifestation of a disease or disorder in family members of the individual. Genetic information includes, but is not limited to, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by an individual or any family member of the individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman, includes genetic information of any fetus carried by a pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. Genetic information shall not include information about the sex or age of any individual;

4. "Genetic services" mean a genetic test, genetic education, or genetic counseling, including, but not limited to, obtaining, interpreting, or assessing genetic information;

5. "Genetic test" means an analysis of the human DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations or chromosomal changes. "Genetic test" shall not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved;

6. "Insurer" means any individual, corporation, association, partnership, insurance support organization, fraternal benefit society, insurance producer, third-party administrator, self-insurer, or any other legal entity engaged in the business of insurance which is licensed to do business in or incorporated or domesticated or domiciled in or under the statutes of this state, or actually engaged in business in this state, regardless of where the contract of insurance is written or plan is administered or where the corporation is incorporated, that issues accident and health policies or plans or that administers any other type of health insurance policy containing medical provisions including, but not limited to, any nonprofit hospital service and indemnity and medical service and indemnity corporation, health maintenance organizations, preferred provider organizations, prepaid health plans and the State and Education Employees Group Health Insurance Plan. Insurer shall not include insurers issuing life, disability income, or long-term care insurance;

7. "Policy" or "policy form" means any policy, contract, plan or agreement of accident and health insurance, or subscriber

certificates of medical care corporations, health care corporations, hospital service associations, or health care maintenance organizations, delivered or issued for delivery in this state by any insurer; any certificate, contract or policy issued by a fraternal benefit society; any certificate issued pursuant to a group insurance policy delivered or issued for delivery in this state; and any evidence of coverage issued by a health maintenance organization. Policy or policy form shall not include life, disability income, and long-term care insurance policies; and

8. "Underwriting purposes" means:

- a. rules for, or determination of, eligibility, including but not limited to enrollment and continued eligibility, for benefits under the policy,
- b. the computation of premium or contribution amounts under the policy,
- c. the application of any preexisting condition exclusion under the policy, and
- d. other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

C. No insurer offering an individual or group accident and health insurance policy shall:

1. Deny or condition the issuance or effectiveness of the policy or certificate, including but not limited to the imposition of any exclusion of benefits under the policy based on a preexisting condition, on the basis of the genetic information with respect to any individual; and

2. Discriminate in the pricing of the policy or certificate, including but not limited to the adjustment of premium rates, of an individual on the basis of the genetic information with respect to any individual.

D. Nothing in subsection C of this section shall be construed to limit the ability of an insurer, to the extent otherwise permitted under this title, from:

1. Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for a group on the basis of manifestations of any condition, disease or disorder of an insured or applicant; or

2. Increasing the premium for any policy or certificate issued to an individual based on the manifestation of a condition, disease or disorder of an individual who is covered under the policy. The manifestation of a disease or disorder in one individual shall not also be used as genetic information about other group members and to further increase the premium for the group.

E. An insurer shall not request or require an individual or a family member of an individual to undergo a genetic test.

F. Subsection E of this section shall not be construed to preclude an insurer from obtaining and using the results of a genetic test in making a determination regarding payment, as defined for the purposes of applying the regulations promulgated under part C of Title XI and Section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time, and consistent with subsection C of this section.

G. In accordance with subsection F of this section, an insurer may request only the minimum amount of information necessary to accomplish the intended purpose.

H. Notwithstanding subsection E of this section, an insurer may request, but shall not require, that an individual or a family member of an individual undergo a genetic test if each of the following conditions is met:

1. The request is made pursuant to research that complies with part 46 of Title 45, Code of Federal Regulations, or equivalent Federal regulations, and any applicable state or local law or regulations for the protection of human subjects in research;

2. The insurer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of the minor child, to whom the request is made that:

- a. compliance with the request is voluntary, and
- b. noncompliance shall have no effect on enrollment status or premium or contribution amounts;

3. No genetic information collected or acquired pursuant to the Genetic Nondiscrimination in Insurance Act shall be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate;

4. The insurer notifies the Secretary of Health and Human Services in writing that the insurer is conducting activities pursuant to the exception provided for under this subsection, including but not limited to a description of the activities conducted; and

5. The insurer complies with other conditions as the Secretary of Health and Human Services may by regulation require for activities conducted pursuant to this subsection.

I. An insurer shall not request, require, or purchase genetic information for underwriting purposes.

J. An insurer shall not request, require, or purchase genetic information with respect to any individual prior to the enrollment of the individual under the policy in connection with the enrollment.

K. If an insurer obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, the request, requirement, or purchase shall not be considered a violation of subsection J of this section if the

request, requirement, or purchase is not in violation of subsection I of this section.

Added by Laws 1998, c. 334, § 1, eff. July 1, 1998. Amended by Laws 2010, c. 222, § 27, eff. Nov. 1, 2010.

§36-3614.2. Genetic nondiscrimination in employment.

A. This section shall be known and may be cited as the "Genetic Nondiscrimination in Employment Act".

B. For purposes of the Genetic Nondiscrimination in Employment Act:

1. "DNA" means deoxyribonucleic acid;

2. "Employer" means employer as such term is defined in Section 3(d) of the Fair Labor Standards Act of 1938, 29 U.S.C., Section 203(d);

3. "Genetic information" means information derived from the results of a genetic test. Genetic information shall not include family history, the results of a routine physical examination or test, the results of a chemical, blood or urine analysis, the results of a test to determine drug use, the results of a test for the presence of the human immunodeficiency virus, or the results of any other test commonly accepted in clinical practice at the time it is ordered by the insurer;

4. "Genetic test" means a laboratory test of the DNA, RNA, or chromosomes of an individual for the purpose of identifying the presence or absence of inherited alterations in the DNA, RNA, or chromosomes that cause a predisposition for a clinically recognized disease or disorder. "Genetic test" shall not include:

a. a routine physical examination or a routine test performed as a part of a physical examination,

b. a chemical, blood, or urine analysis,

c. a test to determine drug use,

d. a test for the presence of the human immunodeficiency virus, or

e. any other test commonly accepted in clinical practice at the time it is ordered by the insurer; and

5. "RNA" means ribonucleic acid.

C. For purposes of distinguishing between or discriminating against or restricting any right or benefit otherwise due or available to an employee or prospective employee, other than in connection with the determination of insurance coverage or benefits, no employer shall:

1. Seek to obtain, or use a genetic test or genetic information of the employee or the prospective employee; or

2. Require a genetic test of or require genetic information from the employee or prospective employee.

D. Any employer violating the provisions of this section, upon conviction thereof, shall be guilty of a misdemeanor and may be

punished by a fine of not more than Twenty-five Thousand Dollars (\$25,000.00) or by imprisonment in the county jail for not more than one (1) year, or by both fine and imprisonment.

E. Notwithstanding any language in this section to the contrary, this section shall not apply to an insurer or to an individual or third-party dealing with an insurer in the ordinary course of underwriting, conducting, or administering the business of life, disability income, or long-term care insurance, including, but not limited to, actions taken by an insurer or to an individual or third-party dealing with an insurer in connection with life, disability income, or long-term care insurance made available by an employer to its employees.

Added by Laws 1998, c. 334, § 2, eff. July 1, 1998.

§36-3614.3. Disclosure of genetic information.

A. No person who maintains genetic information shall be compelled to disclose such information pursuant to a request for compulsory disclosure in any judicial, legislative, or administrative proceeding, unless:

1. The request for compulsory disclosure is in accordance with court-ordered paternity testing in a civil action to determine paternity;

2. The individual whose genetic information is requested is a party to the proceeding and the genetic information is at issue;

3. The individual whose genetic information was requested was insured under an insurance policy and the policy as well as the genetic information is at issue; or

4. The genetic information is for use in a law enforcement proceeding or investigation or in instances where an insurer anticipates or is reporting fraud or criminal activity.

B. Notwithstanding any language in this section to the contrary, this section shall not apply to an insurer or to an individual or third-party dealing with an insurer in the ordinary course of underwriting, conducting, or administering the business of life, disability income, or long-term care insurance or in connection with any judicial, legislative or administrative proceeding relating to life, disability income or long-term care insurance. Nothing in this section is intended to govern an insurer or to govern an individual or third-party dealing with an insurer in connection with the obtaining, maintaining, use, disclosure, or redisclosure of genetic information or the results of a genetic test in connection with life, disability income or long-term care insurance or in connection with any judicial, legislative, or administrative proceeding relating to life, disability income or long-term care insurance.

Added by Laws 1998, c. 334, § 3, eff. July 1, 1998.

§36-3614.4. Disclosure of genetic research studies.

A. This section shall be known and may be cited as the "Genetic Research Studies Nondisclosure Act".

B. For purposes of the Genetic Research Studies Nondisclosure Act, "genetic research study or studies" shall mean those genetic research studies approved by an institutional review board as defined in 21 CFR, Section 50 or conducted subject to the requirements of the federal common rule at 21 CFR, Section 50 and Section 56, and 45 CFR, Section 46.

C. All research records of individual subjects in genetic research studies shall be confidential, meaning the records shall not be subject to subpoena or discovery in civil suits, except in cases where the information in the records is the basis of the suit. The records shall not be disclosed to employers or health insurers without the informed consent of the subject.

D. Notwithstanding any language in this section to the contrary, this section shall not apply to an insurer or to an individual or third party dealing with an insurer in the ordinary course of underwriting, conducting or administering the business of life, disability income or long-term care insurance or in connection with any judicial, legislative or administrative proceeding relating to life, disability income or long-term care insurance. Nothing in this section is intended to govern an insurer or to govern an individual or third party dealing with an insurer in connection with the obtaining, maintaining, use, disclosure or redisclosure of genetic information or the results of a genetic test, including but not limited to records of individual subjects in genetic research in connection with life, disability income or long-term care insurance or in connection with any judicial, legislative or administrative proceeding relating to life, disability income or long-term care insurance.

E. All stored tissues, including blood, that arise from surgery, other diagnostic or therapeutic steps, or autopsy may be disclosed for genetic or other research studies if informed consent has been obtained. Informed consent may be included in a section of the consent for treatment, admission to a hospital or clinic, or permission for an autopsy and no other consent shall be required.

F. It shall be permissible to publish or otherwise use the results of genetic research studies for research or educational purposes if no individual subject is identified. If specific informed consent from the individual has been obtained, the individual may be identified.

Added by Laws 1999, c. 82, § 1, eff. Nov. 1, 1999.

§36-3615. Charter or bylaw provisions; incorporation into policy.

No policy shall contain any provisions purporting to make any portion of the charter, bylaws or other constituent document of the

insurer a part of the contract unless such portion is set forth in full in the policy, provided, however, this section shall not apply to the subscriber's agreement or power of attorney of a reciprocal insurer. Any policy provision in violation of this section shall be invalid.

Laws 1957, p. 367, § 3615.

§36-3616. Labeling particular policies.

In every policy wherein the subject of the insurance is a motor vehicle, if the risks insured against do not include bodily injury and property damage liability, the policy and any certificate or memorandum thereof shall have imprinted or stamped on the face and cover or filing back thereof, in a prominent place, the words "THIS POLICY DOES NOT PROVIDE BODILY INJURY AND PROPERTY DAMAGE LIABILITY COVERAGES." The words shall be printed or stamped in red ink with not less than fourteen-point hollow type letters.

Laws 1957, p. 367, § 3616.

§36-3616.1. Coverage of trustor under property or motor vehicle liability policy.

A. Unless specifically excluded in a separate written endorsement between the named insured and the insurer, every property or motor vehicle liability policy issued in the state in which the named insured is a trust created under the laws of this state and the property or motor vehicle is owned by or is an asset of the trust, the trustor of the trust shall also be considered a named insured under the policy and shall be afforded coverage under the policy.

B. Coverage of the trustor of a named insured trust as provided for in subsection A of this section, shall be continuous and shall not be limited unless specifically provided for in the policy.

Added by Laws 1997, c. 69, § 1, emerg. eff. April 9, 1997.

§36-3617. Policy restrictions voided.

No policy delivered or issued for delivery in Oklahoma and covering a subject of insurance resident, located, or to be performed in Oklahoma, shall contain any condition, stipulation or agreement (1) requiring such policy to be construed according to the laws of any other state or country, except as necessary to meet the requirements of the motor vehicle financial responsibility laws or compulsory disability benefit laws of such other state or country, or (2) preventing the bringing of an action against any such insurer for more than six (6) months after the cause of action accrues, or (3) limiting the time within which an action may be brought to a period of less than two (2) years from the time the cause of action accrues in connection with all insurances other than property and marine and transportation insurances; in property and marine and

transportation policies such time shall not be limited to less than one (1) year from the date of occurrence of the event resulting in the loss. Any such condition, stipulation or agreement shall be void, but such voidance shall not affect the validity of the other provisions of the policy.

Laws 1957, p. 367, § 3617.

§36-3618. Execution of policies.

A. Every insurance policy shall be executed in the name of and on behalf of the insurer by its officer, attorney-in-fact, employee, or representative duly authorized by the insurer.

B. A facsimile signature of any such executing individual may be used in lieu of an original signature.

C. No insurance contract heretofore or hereafter issued and which is otherwise valid shall be rendered invalid by reason of the apparent execution thereof on behalf of the insurer by the imprinted facsimile signature of an individual not authorized so to execute as of the date of the policy, if the policy is countersigned with the original signature or initial of an individual then so authorized.

Laws 1957, p. 367, § 3618.

§36-3619. Underwriters' and combination policies.

A. Two or more authorized insurers may jointly issue, and shall be jointly and severally liable on, an underwriters' policy bearing their names. Any one insurer may issue policies in the name of an underwriter's department and such policy shall plainly show the true name of the insurer.

B. Two or more insurers may, with the approval of the Insurance Commissioner, issue a combination policy which shall contain provisions substantially as follows:

1. That the insurers executing the policy shall be severally liable for the full amount of any loss or damage, according to the terms of the policy, or for specified percentages or amounts thereof, aggregating the full amount of insurance under the policy, and

2. That service of process, or of any notice or proof of loss required by such policy, upon any of the insurers executing the policy, shall constitute service upon all such insurers.

C. Two or more insurers may, with the approval of the Insurance Commissioner, issue a combination policy wherein the subject of insurance is insured against specific risks or perils. In such policy the liability for specific risks or perils assumed by each insurer shall be clearly set out, and each insurer shall be liable only for the risks or perils specifically assumed.

D. This section shall not apply to co-surety obligations.

Laws 1957, p. 368, § 3619.

§36-3620. Validity of noncomplying forms.

Any insurance policy, rider, or endorsement hereafter issued and otherwise valid which contains any condition or provision not in compliance with the requirements of this Code, shall not be thereby rendered invalid but shall be construed and applied in accordance with such conditions and provisions as would have applied had such policy, rider, or endorsement been in full compliance with this Code.

Laws 1957, p. 368, § 3620.

§36-3621. Construction of policies.

Every insurance contract shall be construed according to the entirety of its terms and conditions as set forth in the policy and as amplified, extended, or modified by any rider, endorsement, or application attached to and made a part of the policy.

Added by Laws 1957, p. 368, § 3621, operative July 1, 1957.

§36-3622. Binders.

A. Binders or other contracts for temporary insurance may be made orally or in writing, and shall be deemed to include all the usual terms of the policy as to which the binder was given together with such applicable endorsements as are designated in the binder, except as superseded by the clear and express terms of the binder.

B. No binder shall be valid beyond the issuance of the policy with respect to which it was given, or beyond ninety (90) days from its effective date, whichever period is the shorter.

C. If the policy has not been issued a binder may be extended or renewed beyond such ninety (90) days with the written approval of the Insurance Commissioner, or in accordance with such rules and regulations relative thereto as the Commissioner may promulgate.

D. This section shall not apply to life or accident and health insurances.

Laws 1957, p. 368, § 3622.

§36-3623. Repealed by Laws 1997, c. 418, § 125, eff. Nov. 1, 1997.

§36-3623.1. Fees - Definitions.

A. Nothing in this Code shall be construed to prevent an insurer from charging and collecting in this state separate initial membership fees, policy fees and any other fees as defined in subsection C of this section in addition to premiums for insurance, and such fees shall not be considered premium within the definition of this Code, but shall be subject to premium tax as provided in this Code. An insurer shall fully disclose all fees to its customers.

B. A minimum premium charge is considered premium within the definition of this Code, and shall be subject to premium tax as provided in this Code.

C. 1. Fees are defined as a flat amount added to the basic premium rate to reflect the cost of establishing the required records, sending premium notices and other related expenses and include, but are not limited to, the following: Installment fees, service charges, financing fees, membership fees, return check fees, policy fees, motor vehicle record fees, inspection fees, late fees, electronic transfer fees, credit score fees and expense load fees.

2. The fee passed on to the consumer must be the actual expense incurred by the insurance company, insurance agency or insurance producer.

D. Minimum premium charge is the smallest acceptable premium for which an insurance company will write a policy. This minimum charge is necessary to cover fixed expenses, other than those expenses defined as fees above, in placing the policy on the books. A minimum premium charge includes, but is not limited to, minimum earned premium and minimum retained premium.

E. An insurance producer, limited lines producer, managing general agent, or surplus lines insurance broker cannot charge a duplicate fee or minimum premium charge.

Added by Laws 1957, p. 369, § 3623.1, operative July 1, 1957.

Amended by Laws 2002, c. 307, § 27, eff. Nov. 1, 2002; Laws 2022, c. 154, § 4, eff. Nov. 1, 2022.

§36-3623.2. Death of insured - Refund of premiums.

A. Premiums paid for coverage of life, accident and health insurance shall be refunded from the date of death of the insured to the premium due date.

1. The refund of premium shall be on a daily pro-rata basis.

2. Premium refunds shall be provided within ninety (90) days from the date of valid proof of loss has been received.

B. As it pertains to this section, life, accident and health insurance coverage shall include any policy, contract, plan or agreement of life, accident and health insurance, or subscriber certificates of life or medical care corporations, health care corporations, hospital service associations, or health care maintenance organizations, delivered or issued for delivery in this state by any insurer; any certificate, contract or policy issued by a fraternal benefit society; any policy or certificate issued pursuant to a group insurance policy delivered or issued for delivery in this state; and any evidence of coverage issued by a health maintenance organization. Life, accident and health insurance coverage shall include long-term care, dental, vision and disability insurance policies and certificates.

Added by Laws 2002, c. 307, § 28, eff. Nov. 1, 2002.

§36-3623.3. Charging insurance producer for documentation costs.

No insurer, at any time, shall charge the insurance producer for any costs associated with the necessary documentation or records needed to underwrite a policy. The provisions of this section shall apply only to personal insurance as defined in Section 952 of Title 36 of the Oklahoma Statutes.

Added by Laws 2011, c. 360, § 42.

§36-3624. Assignment of policies.

Except as provided in Section 6055 of this title, a policy may be assignable or not assignable, as provided by its terms. Subject to its terms relating to assignability, any life or accident and health policy, whether heretofore or hereafter issued, under the terms of which the beneficiary may be changed upon the sole request of the insured, may be assigned either by pledge or transfer of title, by an assignment executed by the insured alone and delivered to the insurer, whether or not the pledgee or assignee is the insurer. Any such assignment shall entitle the insurer to deal with the assignee as the owner or pledgee of the policy in accordance with the terms of the assignment, until the insurer has received at its home office written notice of termination of the assignment or pledge, or written notice by or on behalf of some other person claiming some interest in the policy in conflict with the assignment.

Added by Laws 1957, p. 369, § 3624, operative July 1, 1957. Amended by Laws 1992, c. 370, § 1, eff. Sept. 1, 1992; Laws 1999, c. 331, § 10, eff. Nov. 1, 1999; Laws 2002, c. 307, § 29, eff. Nov. 1, 2002; Laws 2023, c. 158, § 1, eff. Nov. 1, 2023.

§36-3624.1. Group life insurance policies - Right to assign incidents of ownership.

A person whose life is insured under a group insurance policy may, subject and pursuant to the terms of the policy, or pursuant to an arrangement between the insured, the group policyholder and the insurer, assign all or any part of his incidents of ownership, rights, title and interests, both present and future, under such policy including specifically, but not by way of limitation, the right to designate a beneficiary or beneficiaries thereunder and the right to have an individual policy issued to him in case of termination of employment or of said group insurance policy. Such an assignment by the insured, made either before or after the effective date of this section, is valid for the purpose of vesting in the assignee, in accordance with any provisions included therein as to the time at which it is to be effective, all of such incidents of ownership, rights, title and interests so assigned, but without prejudice to the insurer on account of any payment it may make or

individual policy it may issue prior to receipt of notice of the assignment. This section acknowledges, declares and codifies the existing right of assignment of interests under group insurance policies.

Laws 1973, c. 19, § 1, emerg. eff. April 4, 1973.

§36-3624.2. Definitions.

As used in this act:

1. "Insurer" means any insurance company that administers accident and health policies or plans or that administers any other type insurance policy containing medical provisions, and any nonprofit hospital service and indemnity and medical service and indemnity corporation, licensed to do business in or incorporated or domesticated or domiciled in or under the statutes of this state, or actually engaged in business in this state, regardless of where the contract of insurance is written or plan is administered or where the corporation is incorporated.

2. "Medical Assistance" means medical services or payments from a program administered by the Department of Human Services which provides medical services or payments for medical services to individuals based on a finding of financial need.

Laws 1981, c. 172, § 1.

§36-3624.3. Direct payments to Department for reimbursement of medical assistance - Notice of claim - Discharge of obligation.

A. Notwithstanding the provisions of Section 3624 of this title, whenever an insurer who has not discharged its obligation to make payments to an individual for medical services, and if that individual has received medical assistance from the Department of Human Services, then the insurer, upon notice that medical assistance has been furnished, shall make its payments directly to the Department of Human Services, but not to exceed the amount of medical assistance paid by the Department of Human Services or medical service rendered by the Department.

B. Provided further, and notwithstanding the provisions of Section 3626 of this title, any insurer who, after having been put on notice of payment of a medical claim or claims or the rendering of medical services by the Department of Human Services, and in disregard of said notice, subsequently makes payments on the same claim or claims to persons or entities other than the Department of Human Services shall not be discharged from payment to the Department of Human Services in the sum and amount claimed by the Department. Payment to the Department by the insurer under the provisions of this section shall discharge the insurer's obligation with respect to all further payment on the claim or claims for the amount paid.

C. Provided, further, that the notice requirements of this act are satisfied (1) when the insurer receives a copy of the claims paid or medical services rendered by the Department of Human Services together with a request for reimbursement by certified or registered mail, or (2) when the insurer receives a claim from a beneficiary containing information to the effect that the beneficiary has applied for or has received medical assistance from the Department of Human Services in connection with the same claim as set forth in Section 3 of this act.

The insurer who receives such claim shall notify the Department of Human Services of its obligation on such claim and shall pay the obligation to the provider of service or if the Department of Human Services has provided medical assistance thereon, pay the Department of Human Services.

Laws 1981, c. 172, § 2.

§36-3624.4. Notice to insurer of assistance received - Violations.

A. Any person who has an application pending or who has received medical assistance from the Department of Human Services and files a claim with any insurer for benefits shall at that time advise the insurer of the receipt of or pending application for medical assistance from the Department of Human Services in connection with the same medical expenses. It shall be the duty of the Department of Human Services to notify the applicant for medical assistance of the requirements of this section.

B. Any person who fails to comply with the provisions of subsection A of this section shall be guilty of a misdemeanor.

Laws 1981, c. 172, § 3.

§36-3624.5. Limiting payments by insurer based upon eligibility for medical assistance prohibited.

Any clause of an insurance contract, plan or agreement administered by an insurer that limits or excludes payments if the individual is eligible for medical assistance is void.

Laws 1981, c. 172, § 4.

§36-3624.6. Conflicting provisions.

Any and all policies of insurance, or any plan or agreement administered by an insurer, issued, entered into, amended or renewed after the effective date of this act containing any provisions contrary to or in conflict with this act are void as to those provisions only; all remaining provisions in the contract not in conflict with these sections that are severable shall remain in full force and effect.

Laws 1981, c. 172, § 5.

§36-3624A. Repealed by Laws 1992, c. 370, § 3, eff. Sept. 1, 1992.

§36-3624B. Repealed by Laws 1992, c. 370, § 3, eff. Sept. 1, 1992.

§36-3625. Annulment of liability policies.

A. No insurance contract insuring against loss or damage through legal liability for the bodily injury or death by accident of any individual, or for damage to the property of any person, shall be retroactively annulled by any agreement between the insurer and the insured after the occurrence of any such injury, death, or damage for which the insured may be liable, and any such attempted annulment shall be void.

B. The provisions of subsection A of this section shall not apply to a claim made and reported from a liability insurance policy unless there is actual notice that a claim or potential claim has been made against an insured who shall have also reported the claim or potential claim to the insured's insurer.

Added by Laws Laws 1957, p. 369, § 3625. Amended by Laws 2016, c. 14, § 1, eff. Nov. 1, 2016.

§36-3626. Payment discharges insurer.

Whenever the proceeds of or payments under a life or accident and health insurance policy or annuity contract heretofore or hereafter issued become payable in accordance with the terms of such policy or contract, or the exercise of any right or privilege thereunder, and the insurer makes payment thereof in accordance with the terms of the policy or contract or in accordance with any written assignment thereof, the person then designated in the policy or contract or by such assignment as being entitled thereto shall be entitled to receive such proceeds or payments and to give full acquittance therefor, and such payments shall fully discharge the insurer from all claims under the policy or contract unless, before payment is made, the insurer has received at its home office written notice by or on behalf of some other person that such other person claims to be entitled to such payment or some interest in the policy or contract.

Laws 1957, p. 369, § 3626.

§36-3627. Minor may give acquittance.

Any minor domiciled in this state who has attained the age of sixteen (16) years shall be deemed competent to receive and to give full acquittance and discharge for a payment or payments in aggregate amount not exceeding Two Thousand Dollars (\$2,000.00) in any one (1) year made by a life insurer as benefits payable to such minor in compliance with the provisions of an insurance policy, annuity contract or settlement agreement. No such minor shall be deemed competent to alienate the right to or to anticipate such payments.

This section shall not be deemed to restrict the rights of minors set forth in subsection B of Section 3606 of this article. Laws 1957, p. 369, § 3627.

§36-3628. Simultaneous deaths.

Where the individual insured or the annuitant and the beneficiary designated in a life insurance policy or policy insuring against accidental death or in an annuity contract have died and there is not sufficient evidence that they have died otherwise than simultaneously, the proceeds of the policy or contract shall be distributed as if the insured or annuitant had survived the beneficiary, unless otherwise specifically provided in the policy or contract.

Laws 1957, p. 369, § 3628. x

§36-3629. Forms of proof of loss - Offer of settlement or rejection of claim.

A. An insurer shall furnish, upon written request of any insured claiming to have a loss under an insurance contract issued by such insurer, forms of proof of loss for completion by such person, but such insurer shall not, by reason of the requirement so to furnish forms, have any responsibility for or with reference to the completion of such proof or the manner of any such completion or attempted completion.

B. It shall be the duty of the insurer, receiving a proof of loss, to submit a written offer of settlement or rejection of the claim to the insured within sixty (60) days of receipt of that proof of loss. Upon a judgment rendered to either party, costs and attorney fees shall be allowable to the prevailing party. For purposes of this section, the prevailing party is the insurer in those cases where judgment does not exceed written offer of settlement. In all other judgments the insured shall be the prevailing party. If the insured is the prevailing party, the court in rendering judgment shall add interest on the verdict at the rate of fifteen percent (15%) per year from the date the loss was payable pursuant to the provisions of the contract to the date of the verdict. This provision shall not apply to uninsured motorist coverage.

Added by Laws 1957, p. 370, § 3629, operative July 1, 1957. Amended by Laws 1977, c. 133, § 1, eff. Oct. 1, 1977; Laws 1985, c. 79, § 1, eff. Nov. 1, 1985; Laws 2018, c. 95, § 8, eff. Nov. 1, 2018.

§36-3630. Claims administration not waiver.

Without limitation of any right or defense of an insurer otherwise, none of the following acts by or on behalf of an insurer shall be deemed to constitute a waiver of any provision of a policy or of any defense of the insurer thereunder:

1. Acknowledgment of the receipt of notice of loss or claim under the policy.

2. Furnishing forms for reporting a loss or claim, for giving information relative thereto, or for making proof of loss, or receiving or acknowledging receipt of any such forms or proofs completed or uncompleted.

3. Investigating any loss or claim under any policy or engaging in negotiations looking toward a possible settlement of any such loss or claim.

Laws 1957, p. 370, § 3630.

§36-3631. Repealed by Laws 1992, c. 261, § 5, eff. Sept. 1, 1992.

§36-3631.1. Certain money and benefits exempt from legal process or seizure - Exceptions.

A. All money or benefits of any kind, including policy proceeds and cash values, to be paid or rendered to the insured or any beneficiary under any policy of insurance issued by a life, health or accident insurance company, under any policy issued by a mutual benefit association, or under any plan or program of annuities and benefits, shall:

1. Inure exclusively to the benefit of the person for whose use and benefit the money or benefits are designated in the policy, plan or program;

2. Be fully exempt from execution, attachment, garnishment or other process;

3. Be fully exempt from being seized, taken or appropriated or applied by any legal or equitable process or operation of law to pay any debt or liability of the insured or of any beneficiary, either before or after said money or benefits is or are paid or rendered; and

4. Be fully exempt from all demands in any bankruptcy proceeding of the insured or beneficiary.

B. The exemptions provided by subsection A of this section shall apply without regard to whether:

1. The power to change the beneficiary is reserved to the insured; or

2. The insured or the insured's estate is a contingent beneficiary.

C. The exemptions provided by subsection A of this section do not apply to:

1. Premium payments made in fraud of creditors subject to the applicable statute of limitations for the recovery of the premium payments;

2. Fines imposed for violation of state or federal statutes; or

3. A debt of the insured or beneficiary secured by a pledge of the policy or its proceeds.

D. This section shall not prevent the proper assignment of any money or benefits to be paid or rendered under an insurance policy, or any rights under the policy, by the insured or owner in accordance with the terms of the policy. A policy shall also be deemed to be payable to a person other than the insured if and to the extent that a facility-of-payment clause or similar clause in the policy permits the insurer to discharge its obligation after the death of the individual insured by paying the death benefits to a person as permitted by such clause.

E. Wherever any policy of insurance or plan or program of annuities and benefits mentioned in subsection A of this section shall contain a provision against assignment or commutation by any beneficiary thereunder of the money or benefits to be paid or rendered thereunder, or any rights therein, any assignment or commutation or any attempted assignment or commutation by such beneficiary of such money or benefits or rights in violation of such provision shall be wholly void.

F. This section shall apply to money or benefits to be paid or rendered to an insured or a beneficiary under any policy, plan or program provided for in subsection A of this section without regard to whether the policy was issued or the plan or program was established before, on, or after September 1, 1992.
Added by Laws 1992, c. 261, § 1, eff. Sept. 1, 1992.

§36-3632. Exemption of proceeds, group life.

A. A policy of group life insurance or the proceeds thereof payable to the individual insured or to the beneficiary thereunder, shall not be liable, either before or after payment, to be applied by any legal or equitable process to pay any liability of any person having a right under the policy. The proceeds thereof, when not made payable to a named beneficiary or to a third person pursuant to a facility-of-payment clause, shall not constitute a part of the estate of the individual insured for the payment of his debts.

B. This section shall not apply to group life insurance issued pursuant to Article 41 (Group life insurance and group annuity contracts) to a creditor covering his debtors, to the extent that such proceeds are applied to payment of the obligation for the purpose of which the insurance was so issued.
Laws 1957, p. 370, § 3632.

§36-3633. Policies issued in violation of Code; penalty.

Any insurer or corporation, or any officer or agent thereof, issuing or delivering to any person in this state any policy in willful violation of any provision of this Code shall be guilty of a misdemeanor.
Laws 1957, p. 370, § 3633.

§36-3634. Chiroprody, podiatry, psychology and clinical social work - Accident and health benefits.

Medical or surgical services or procedures constituting the practice of podiatric medicine, as defined by Section 142 of Title 59 of the Oklahoma Statutes, psychological services or procedures constituting the practice of psychology, as defined by Section 1352 of Title 59 of the Oklahoma Statutes, and licensed and certified clinical social work services provided by persons meeting the qualifications required under subsection B of Section 1261.1 of Title 59 of the Oklahoma Statutes and covered by the terms of any individual, group, blanket or franchise policy, agreement or service contract providing accident or health benefits coverage in Oklahoma issued by any insurer, whether a stock or mutual insurance company, a medical service corporation or association, or any other type of issuer whatever, and covering an Oklahoma risk may be performed by any practitioner licensed to do so under Sections 136 through 160.2, Sections 1351 through 1376 or subsection B of Section 1261.1 of Title 59 of the Oklahoma Statutes, who is selected by the insured provided that where covered benefits are offered through a contracting preferred provider organization, the podiatrist, psychologist, or clinical social worker is a contracting provider. Except in the case of a contracting preferred provider organization, any provision, exclusion or limitation in such a policy denying an insured the free choice of such licensed podiatric physician, psychologist or certified clinical social worker shall, to the extent of the denial, be void, but such voidance shall not affect the validity of the other provisions of the policy.

Added by Laws 1963, c. 146, § 1, emerg. eff. June 5, 1963. Amended by Laws 1965, c. 133, § 1, emerg. eff. May 24, 1965; Laws 1974, c. 115, § 1, emerg. eff. May 1, 1974; Laws 1975, c. 79, § 1, emerg. eff. April 22, 1975; Laws 1982, c. 61, § 2, operative Oct. 1, 1982; Laws 1993, c. 26, § 1, eff. Sept. 1, 1993.

§36-3634.1. Prescription drug coverage - Enforcement.

A. This act shall apply to medical benefit contracts, health care centers, insurance companies and health maintenance organizations which provide coverage for prescription drugs.

B. The Insurance Commissioner shall implement and enforce the provisions of this act pursuant to the Oklahoma Insurance Code, Section 101 et seq. of this title.

Added by Laws 1994, c. 141, § 1, eff. Sept. 1, 1994.

§36-3634.2. Prescription drug coverage - Definitions.

As used in this act:

1. "Co-payment" means a type of cost sharing whereby insured or covered persons pay a specified predetermined amount per unit of service with their insurer paying the remainder of the charge. The

co-payment is incurred at the time the service is rendered. The co-payment may be a fixed or variable amount;

2. "Contract provider" means a pharmacy or pharmacist granted the right to provide prescription drugs and pharmacy services according to the terms of the insurer;

3. "Insurer" means any individual, plan, policy or contract that provides health care coverage benefits for pharmacy services including, but not limited to, prescription drugs;

4. "Pharmacist" means any person licensed by the Oklahoma State Board of Pharmacy to practice pharmacy; and

5. "Pharmacy" means a pharmacy licensed by the Oklahoma State Board of Pharmacy.

Added by Laws 1994, c. 141, § 2, eff. Sept. 1, 1994.

§36-3634.3. Prescription drug coverage - Pharmacy contracts - Open pharmacy networks.

A. A health insurance plan or policy or health maintenance organization providing prescription drugs as a covered benefit shall provide a pharmacy or group of pharmacies with the right to bid on a periodic basis, but not less than every three (3) years, on any pharmacy contract to provide pharmacy services, including, but not limited to, prescription drugs.

B. Nothing in this act shall be interpreted to preclude a health insurance plan or policy or health maintenance organization from establishing an open pharmacy network for the provision of pharmacy services, including, but not limited to, prescription drugs.

C. The provisions of this section shall not apply to a health insurance plan or policy or health maintenance organization that maintains an open pharmacy network.

Added by Laws 1994, c. 141, § 3, eff. Sept. 1, 1994.

§36-3634.4. Prescription drug or device coverage - Uniform prescription drug information on card or technology.

A. 1. It is the intent of the Legislature to:

- a. lessen waiting times of patients,
- b. decrease administrative burdens for pharmacies, and
- c. improve care to patients,

by minimizing confusion, eliminating unnecessary paperwork and streamlining dispensing of prescription products paid for by third-party payors.

2. This section shall be broadly applied and interpreted to effectuate this purpose.

B. 1. Each health benefit plan that provides coverage for prescription drugs or devices, or administers such a plan including, but not limited to, third-party administrators for self-insured plans, to the extent permitted by the Employee Retirement Income

Security Act of 1974 (ERISA), and state-administered plans, or the plan's agents or contractors that issue a card or other technology for prescription claims submission and adjudication, shall issue to its insureds covered by such plan a card or other technology containing uniform prescription drug information. Nothing in this section shall require any health benefit plan, or the plan's agents or contractors to issue a separate card or other technology for prescription coverage, provided that the card issued can accommodate the information required by this section.

2. The uniform prescription drug information contained on the insured's card or other technology shall include the following fields:

- a. card issuer name or logo on the front of the card,
- b. complete information for electronic claims routing including:
 - (1) issuer identification number (IIN/BIN) labeled as IIN or BIN,
 - (2) the Processor Control Number (PCN), labeled as PCN, if required for proper routing of electronic claim transactions for prescription benefits, and
 - (3) the group number, labeled as GRP, if required for proper routing of electronic claim transactions for prescription benefits,
- c. card issuer identification,
- d. card holder identification, which shall be displayed on the front of the card,
- e. card holder name, which shall be displayed on the front of the card,
- f. claims processor name and, if not filed electronically, address, and
- g. a help desk phone number that pharmacy providers may call for pharmacy benefit claims assistance.

C. 1. The new uniform prescription drug information contained on the insured's card or other technology, as required by subsection B of this section, shall be issued by a health benefit plan or the plan's administrators, agents or contractors upon enrollment, and reissued within a reasonable time upon any change in the coverage of the insured person that impacts data contained on the card.

2. Newly issued cards or technology shall be updated with the latest coverage information.

D. As used in this section, "health benefit plan" means an accident and health insurance policy or certificate, a nonprofit hospital or medical service corporation contract, a health maintenance organization subscriber contract, a plan provided by a multiple employer welfare arrangement, or a plan provided by another benefit arrangement, to the extent permitted by ERISA of 1974, as amended, or by any waiver of or other exception to that act provided

under federal law or regulation. The term "health benefit plan" shall not include the following types of insurance:

1. Accident;
2. Credit;
3. Disability income;
4. Long-term or nursing home care;
5. Specified disease;
6. Dental or vision;
7. Coverage issued as a supplement to liability insurance;
8. Medical payments under automobile or homeowners;
9. Insurance under which benefits are payable with or without regard to fault and this is statutorily required to be contained in any liability policy or equivalent self-insurance;
10. Health benefit plans that participate or contract with the Oklahoma Health Care Authority as the state Medicaid agency; and
11. Hospital income or indemnity.

E. The provisions of this section shall apply to health benefit plans that are delivered, issued for delivery, or renewed on and after January 1, 2004.

F. 1. Enforcement of the provisions of this section shall be the responsibility of the Insurance Commissioner.

2. The Insurance Commissioner shall promulgate rules necessary to effectuate the provisions of this section.

3. The Insurance Commissioner shall take action or impose appropriate penalties to bring noncomplying entities into full compliance with the provisions of this section.

Added by Laws 2002, c. 409, § 2, eff. Nov. 1, 2003.

§36-3634.5. Synchronization of prescription drug refills.

A. A health benefit plan that provides benefits for prescription drugs delivered, issued or renewed after November 1, 2017, shall provide for synchronization of prescription drug refills on at least one occasion per insured per year, provided all of the following conditions are met:

1. The prescription drugs are covered by the health benefit plan's clinical coverage policy or have been approved by a formulary exceptions process;

2. The prescription drugs are maintenance medications as defined by the plan and have available refill quantities at the time of synchronization;

3. The medications are not Schedule II, III or IV controlled substances;

4. The insured meets all utilization management criteria to the prescription drugs at the time of synchronization;

5. The prescription drugs are of a formulation that can be safely split into short-fill periods to achieve synchronization;

6. The prescription drugs do not have special handling or sourcing needs as determined by the plan, contract, or agreement that require a single, designated pharmacy to fill or refill the prescription; and

7. The covered person agrees to the synchronization.

B. When necessary to permit synchronization, the health benefit plan shall apply a prorated daily cost-sharing rate to any medication dispensed by a network pharmacy pursuant to this section. No dispensing fees shall be prorated, and all dispensing fees shall be based on the number of prescriptions filled or refilled.

C. As used in this section, "synchronization" means the coordination of medication refills for a patient taking two or more medications for one or more chronic conditions such that the patient's medications are refilled on the same schedule for a given time period.

Added by Laws 2017, c. 140, § 1, eff. Nov. 1, 2017.

§36-3634.6. Direct payment or reimbursement to pharmacist.

An insurer, as defined in Section 3634.2 of Title 36 of the Oklahoma Statutes, shall provide direct payment or reimbursement to a pharmacist licensed in this state for providing a health care service to an individual if:

1. The pharmacist provided any health care service he or she is licensed to perform in the practice of pharmacy, as defined in Section 353.1 of Title 59 of the Oklahoma Statutes, in this state; and

2. The health benefit policy, contract or agreement of the individual provides for payment or reimbursement of the service.

Added by Laws 2021, c. 435, § 1, eff. Jan. 1, 2022.

NOTE: Editorially renumbered from § 3436.6 of this title to maintain consistency in numbering.

§36-3634.11. Coverage of vision care or medical diagnosis and treatment services - Referral to optometrists - Equal compensation.

A. Any health benefit plan which offers services for vision care or medical diagnosis and treatment for the eye shall allow optometrists to be providers of those services.

B. With respect to optometric services, any health benefit plan which uses a gatekeeper or equivalent for referrals for services for vision care or for medical diagnosis and treatment of the eye shall require such covered services be provided on a referral basis within the medical group or network at the request of an enrollee who has a condition requiring vision care or medical diagnosis and treatment of the eye if:

1. A referral is necessitated in the judgment of the primary care physician; and

2. Treatment for the condition falls within the licensed scope of practice of an optometrist.

C. Each health benefit plan shall have a defined set of standards and procedures for selecting providers, including specialists, to serve enrollees. The standards and procedures shall be drafted in such a manner that they are applicable to all categories of providers and shall be utilized by the health benefit plan in a manner that is without bias for or discrimination against a particular category or categories of providers.

D. No health benefit plan shall require a provider to have hospital privileges if hospital privileges are not usual and customary for the services the provider provides.

E. Health benefit plans shall provide that optometrists 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 as provided in the Health Care Freedom of Choice Act, if the services are within the scope of practice of optometry.

F. Nothing in this section shall be construed to:

1. Prohibit a health benefit plan which offers services for vision care or medical diagnosis and treatment for the eye from determining the adequacy of the size of its network;

2. Prohibit an optometrist from agreeing to a fee schedule;

3. Limit, expand, or otherwise affect the scope of practice of optometry; or

4. Alter, repeal, modify or affect the laws of this state except where such laws are in conflict or are inconsistent with the express provisions of this section.

G. Existing health benefit plans shall comply with the requirements of this section upon issuance or renewal on or after the effective date of this act.

H. As used in this section, "health benefit plan" means individual or group hospital or medical insurance coverage, a not-for-profit hospital or medical service or indemnity plan, a prepaid health plan, a health maintenance organization plan, a preferred provider organization plan, the State and Education Employees Group Health Insurance Plan, any program funded under Title XIX of the Social Security Act or such other publicly funded program, and coverage provided by a Multiple Employer Welfare Arrangement (MEWA) or employee self-insured plan except as exempt under federal ERISA provisions.

Added by Laws 2000, c. 54, § 1, eff. Nov. 1, 2000.

§36-3635. "Motor vehicle" defined.

The term "motor vehicle" as used in this act means and includes a self-propelled land motor vehicle designed for use principally

upon public roads or streets but does not mean or include crawler or farm-type tractors, farm implements and, if not subject to motor vehicle registration, any equipment which is designed for use principally off public roads and streets.
Laws 1968, c. 106, § 1, eff. July 1, 1968.

§36-3635.1. Time of expiration of certain policies.

All policies 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, as defined in Section 3635 of this title, shall expire at 12:01 a.m. Standard Time on the expiration date stated in the policy. This section shall apply to all such policies on the first policy renewal date after December 31, 1982.
Amended by Laws 1982, c. 57, § 1, eff. Jan. 1, 1983.

§36-3636. Uninsured motorist coverage.

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. Policies issued, renewed or reinstated after November 1, 2014, shall not be subject to stacking or aggregation of limits unless expressly provided for by an insurance carrier. 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. The form signed by the insured or applicant which initially rejects coverage or selects lower limits shall remain valid for the life of the policy and the completion of a new selection form shall not be required when a renewal, reinstatement, substitute, replacement, or amended policy is issued to the same-named insured by the same insurer or any of its affiliates. Any changes to an existing policy, regardless of whether these changes create new coverage, do not create a new policy and do not require the completion 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.

H. 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 by indicating 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 \$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.

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

J. 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 and shall not require the completion of a new form.

K. 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.

Added by Laws 1968, c. 106, § 2, eff. July 1, 1968. Amended by Laws 1976, c. 28, § 1, emerg. eff. March 16, 1976; Laws 1979, c. 178, § 1, emerg. eff. May 16, 1979; Laws 1989, c. 98, § 1, eff. Nov. 1, 1989; Laws 1990, c. 297, § 4, eff. Sept. 1, 1990; Laws 1994, c. 294, § 5, eff. Sept. 1, 1994; Laws 2001, c. 209, § 1, eff. Nov. 1, 2001; Laws 2001, c. 363, § 18, eff. July 1, 2001; Laws 2004, c. 519, § 25, eff. Nov. 1, 2004; Laws 2009, c. 7, § 1, eff. Nov. 1, 2009; Laws 2009, c. 176, § 31, eff. Nov. 1, 2009; Laws 2014, c. 307, § 1, eff. Nov. 1, 2014.

§36-3637. Exceptions.

This act shall not apply to any policy covering motor trucks operated by a motor carrier as defined in 47 O.S. 1961, Section 161, as amended, where the named insured has employees who operate motor trucks or to any other commercial automobile liability policy covering motor trucks where the named insured has employees and such employees are covered by workers' compensation on the effective date of the policy.

Added by Laws 1968, c. 106, § 3, eff. July 1, 1968. Amended by Laws 2004, c. 267, § 1, eff. Nov. 1, 2004.

§36-3639. Application of cancellation requirements to certain policies - Definitions - Notice and reasons for cancellation or nonrenewal - Notice of premium increases.

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

B. As used in this section:

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

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

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

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

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

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

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

1. Nonpayment of premium;

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

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

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

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

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

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

8. Loss of or substantial changes in applicable reinsurance.

D. An insurer may refuse to renew a policy if the insurer gives to the first-named insured at the address shown on the policy written notice that the insurer will not renew the policy. Such notice shall be given at least forty-five (45) days before the expiration date. Notice may be sent by electronic means if the recipient consents to such method of delivery and the insurer is in compliance with the provisions of the Uniform Electronic Transactions Act. Electronic delivery is considered to be equivalent to any delivery method required by law, including first-class mail, postage prepaid, certified mail, certificate of mail, or certificate of mailing. If notice is given by mail or sent by electronic means, such notice shall be deemed to have been given on the day the notice is mailed or sent electronically. If the notice is mailed or sent electronically less than forty-five (45) days before expiration, coverage shall remain in effect until forty-five

(45) days after notice is mailed or sent electronically. Earned premium for any period of coverage that extends beyond the expiration date shall be considered pro rata based upon the previous year's rate. For purposes of this section, the transfer of a policyholder between companies within the same insurance group is not a refusal to renew. In addition, changing deductibles, changes in premium, changes in the amount of insurance, or reductions in policy limits or coverage are not refusals to renew.

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

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

E. An insurer shall give to the named insured at the mailing address shown on the policy, written notice of premium increase, change in deductible, reduction in limits or coverage at least forty-five (45) days prior to the expiration date of the policy. If the insurer fails to provide such notice, the premium, deductible, limits and coverage provided to the named insured prior to the change shall remain in effect until notice is given or until the effective date of replacement coverage obtained by the named insured, whichever first occurs. If notice is given by mail, such notice shall be deemed to have been given on the day the notice is mailed. If the insured elects not to renew, any earned premium for the period of extension of the terminated policy shall be calculated pro rata at the lower of the current or previous year's rate. If the insured accepts the renewal, the premium increase, if any, and other changes shall be effective the day following the prior policy's expiration or anniversary date.

This subsection shall not apply to:

1. Changes in a rate or plan filed with or approved by the Insurance Commissioner or filed pursuant to the Property and Casualty Competitive Loss Cost Rating Act and applicable to an entire class of business;

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

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

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

Added by Laws 1985, c. 328, § 21, emerg. eff. July 29, 1985.

Amended by Laws 1987, c. 175, § 32, eff. Nov. 1, 1987; Laws 1988, c.

291, § 5, eff. Nov. 1, 1988. Renumbered from § 4807 of this title by Laws 1988, c. 291, § 6, eff. Nov. 1, 1988. Amended by Laws 2000, c. 353, § 15, eff. Nov. 1, 2000; Laws 2001, c. 363, § 19, eff. July 1, 2001; Laws 2005, c. 129, § 14, eff. Nov. 1, 2005; Laws 2006, c. 264, § 60, eff. July 1, 2006; Laws 2007, c. 125, § 19, eff. July 1, 2007; Laws 2024, c. 130, § 1, eff. Nov. 1, 2024.

§36-3639.1. Personal residential insurance - Cancellation, nonrenewal or increase in premium for filing first claim - Notice.

A. No insurer shall cancel, refuse to renew or increase the premium of a homeowner's insurance policy or any other personal residential insurance coverage, which has been in effect more than forty-five (45) days, solely because the insured filed a first claim against the policy. The provisions of this section shall not be construed to prevent the cancellation, nonrenewal or increase in premium of a homeowner's insurance policy for the following reasons:

1. Nonpayment of premium;
2. Discovery of fraud or material misrepresentation in the procurement of the insurance or with respect to any claims submitted thereunder;
3. Discovery of willful or reckless acts or omissions on the part of the named insured which increase any hazard insured against;
4. A change in the risk which substantially increases any hazard insured against after insurance coverage has been issued or renewed;
5. Violation of any local fire, health, safety, building, or construction regulation or ordinance with respect to any insured property or the occupancy thereof which substantially increases any hazard insured against;
6. A determination by the Insurance Commissioner that the continuation of the policy would place the insurer in violation of the insurance laws of this state; or
7. Conviction of the named insured of a crime having as one of its necessary elements an act increasing any hazard insured against.

B. An insurer shall give to the named insured at the mailing address shown on a homeowner's policy, a written renewal notice that shall include new premium, new deductible, new limits or coverage at least thirty (30) days prior to the expiration date of the policy. If the insurer fails to provide such notice, the premium, deductible, limits and coverage provided to the named insurer prior to the change shall remain in effect until notice is given or until the effective date of replacement coverage obtained by the named insured, whichever occurs first. If notice is given by mail, the notice shall be deemed to have been given on the day the notice is mailed. If the insured elects not to renew, any earned premium for the period of extension of the terminated policy shall be calculated pro rata at the lower of the current or previous year's rate. If

the insured accepts the renewal, the premium increase, if any, and other changes shall be effective the day following the prior policy's expiration or anniversary date.

C. In the event an insured cancels a homeowner's insurance policy or any other personal residential insurance coverage, written notice shall be provided by the insured to the insurer that provided the coverage being canceled. The notice of cancellation shall provide the date of the cancellation of the policy and the insurer shall reimburse the insured for any premiums paid for coverage beyond the date of cancellation of the policy.

D. An insurer canceling a policy under subsection C of this section shall not be liable for claims arising after the date of cancellation.

Added by Laws 1990, c. 178, § 1, eff. Sept. 1, 1990. Amended by Laws 2011, c. 278, § 27, eff. Nov. 1, 2011; Laws 2012, c. 44, § 11, eff. Nov. 1, 2012; Laws 2021, c. 478, § 21, emerg. eff. May 12, 2021.

§36-3639.2. Policies issued under Market Assistance program - Exemption from §3639.1.

Homeowner insurance policies issued under the voluntary Market Assistance program shall be exempt from this act.

Added by Laws 1990, c. 178, § 2, eff. Sept. 1, 1990.

§36-3639.3. Homeowner coverage as condition of financing - Amount not to exceed replacement value - Definitions.

A. No lender, as a condition of financing a residential mortgage or providing other financing arrangements for residential property, including a mobile or manufactured home, may require a borrower to purchase homeowner insurance coverage, mobile or manufactured home insurance coverage, dwelling fire coverage, or other residential property coverage in an amount that exceeds the replacement value of the dwelling and its contents, regardless of the amount of the mortgage or other financing arrangement entered into by the borrower. As used in this section, "replacement value" shall not include the cleanup costs or the value of outbuildings if the limits of coverage are separate from the dwelling limits coverage.

B. A lender may not include the fair market value of the land on which a dwelling is located in the replacement value of the dwelling and its contents.

C. A lender may accept the value of the dwelling determined by the insurer, or use the value placed on the dwelling that is determined by an appraisal of the real property by the lender to determine the replacement value.

D. As used in this section:

1. "Lender" means any person, partnership, corporation, association, or other entity, or any agent, loan agent, servicing agent, or any loan or mortgage broker, who lends money and receives or otherwise acquires a mortgage, lien, deed of trust, or any other security interest in or upon any real or personal property as security for such loan; and

2. "Borrower" means any person, partnership, corporation, association, or other entity, who has or acquires a legal or equitable interest in real or personal property which is or becomes subject to a mortgage, lien, security agreement, deed of trust, or other security instrument.

Added by Laws 2004, c. 87, § 1, eff. Nov. 1, 2004.

§36-3640. Definitions - Denial of form - Certificate of insurance.

A. As used in this section:

1. "Certificate" or "certificate of insurance" means any document or instrument, no matter how titled or described, which is prepared or issued by an insurer or insurance producer as evidence of property or casualty insurance coverage. "Certificate" or "certificate of insurance" shall not include a policy of insurance or insurance binder;

2. "Certificate holder" means any person, other than a policyholder, that requests, obtains, or possesses a certificate of insurance;

3. "Insurance producer" shall be defined as provided in Section 1435.2 of Title 36 of the Oklahoma Statutes;

4. "Insurer" shall be defined as provided in Section 103 of Title 36 of the Oklahoma Statutes; and

5. "Policyholder" means a person who has contracted with a property or casualty insurer for insurance coverage.

B. No person may prepare, issue, or request the issuance of a certificate of insurance unless the form has been filed with and approved by the Insurance Commissioner, except as provided in subsection E of this section. No person may alter or modify an approved certificate of insurance form.

C. The Commissioner shall disapprove a form filed pursuant to this section, or withdraw approval of a form, if the form:

1. Is unjust, unfair, misleading, or deceptive, or violates public policy;

2. Fails to comply with the requirements of subsection D of this section; or

3. Violates any law, including any regulation adopted by the Insurance Commissioner.

D. Each certificate of insurance shall contain the following or similar statement: "This certificate of insurance is issued as a matter of information only and confers no rights upon the certificate holder. This certificate does not amend, extend, or

alter the coverage, terms, exclusions, and conditions afforded by the policies referenced herein."

E. Standard certificate of insurance forms promulgated by the Association of Cooperative Operations Research and Development or the Insurance Services Office are deemed approved by the Insurance Commissioner and shall not be required to be filed if the forms otherwise comply with the requirements of this section.

F. No person, wherever located, shall demand or require the issuance of a certificate of insurance from an insurer, insurance producer, or policyholder which contains any false or misleading information concerning the policy of insurance to which the certificate makes reference.

G. No person, wherever located, may knowingly prepare or issue a certificate of insurance that contains any false or misleading information or that purports to affirmatively or negatively alter, amend, or extend the coverage provided by the policy of insurance to which the certificate makes reference.

H. No person may prepare, issue, demand, or require, either in addition to or in lieu of a certificate of insurance, an opinion letter or other document or correspondence that is inconsistent with this section; provided, however, an insurer or insurance producer may prepare or issue an addendum to a certificate that clarifies and explains the coverages provided by a policy of insurance and otherwise complies with the requirements of this section.

I. The provisions of this section apply to all certificate holders, policyholders, insurers or insurance producers with regard to a certificate of insurance issued on property or casualty operations or a risk located in this state, regardless of where the certificate holder, policyholder, insurer or insurance producer is located. These provisions shall not be construed to apply to:

1. Evidence of insurance required by a lender in a lending transaction involving:

- a. a mortgage,
- b. a lien,
- c. a deed or trust, or
- d. any other security interest in real or personal property as security for a loan;

2. A certificate issued under:

- a. a group or individual policy for:
 - (1) life insurance,
 - (2) credit insurance,
 - (3) accident and health insurance,
 - (4) long-term care benefit insurance, or
 - (5) Medicare supplement insurance, or
- b. an annuity contract; or

3. Standard proof of motor vehicle liability insurance pursuant to the requirements of Section 3636 of Title 36 of the Oklahoma Statutes.

J. A certificate of insurance is not a policy of insurance and does not affirmatively or negatively amend, extend, or alter the coverage afforded by the policy to which the certificate of insurance makes reference. A certificate of insurance shall not confer to a certificate holder new or additional rights beyond what the referenced policy of insurance expressly provides.

K. No certificate of insurance shall contain references to contracts, including construction or service contracts, other than the referenced contract of insurance. Notwithstanding any requirements, term, or condition of any contract or other document with respect to which a certificate of insurance may be issued or may pertain, the insurance afforded by the referenced policy of insurance shall be subject to all the terms, exclusions and conditions of the policy itself.

L. A certificate holder shall only have a legal right to notice of cancellation, nonrenewal, or any material change, or any similar notice concerning a policy of insurance if the person is named within the policy or any endorsement as an additional insured and the policy or endorsement requires notice to be provided. The terms and conditions of the notice, including the required timing of the notice, are governed by the policy of insurance and cannot be altered by a certificate of insurance.

M. An insurance producer who is not associated with an insurer's captive distribution system may charge a reasonable service fee for issuing a certificate to a policy holder or certificate holder.

N. Any certificate of insurance or any other document or correspondence prepared, issued, demanded, or required in violation of this section shall be null and void and of no force and effect.

O. Any person who violates this section may be fined up to One Thousand Dollars (\$1,000.00) per violation.

P. The Commissioner shall have the authority to examine and investigate the activities of any person that the Commissioner reasonably believes has been or is engaged in an act or practice prohibited by this section. The Commissioner shall have the authority to enforce the provisions of this section and impose any authorized penalty or remedy against any person who violates this section.

Q. The Commissioner may adopt reasonable rules and regulations as are necessary or proper to carry out the provisions of this section.

Added by Laws 2011, c. 278, § 28, eff. Nov. 1, 2011.

§36-3641. Short title.

Sections 1 through 9 of this act shall be known and may be cited as the "Life, Accident and Health Insurance Policy Language Simplification Act".

Added by Laws 1986, c. 141, § 1, eff. Jan. 1, 1987.

§36-3642. Purpose of act - Intent.

A. The purpose of the Life, Accident and Health Insurance Policy Language Simplification Act is to establish minimum standards for language used in policies and certificates of life, accident and health insurance, and subscriber certificates of medical care corporations, health care corporations, hospital service associations, and health maintenance organizations, delivered or issued for delivery in this state, to facilitate ease of reading by insureds and subscribers.

B. The Life, Accident and Health Insurance Policy Language Simplification Act is not intended to increase the risk assumed by insurance companies or other entities or to supercede their obligation to comply with the substance of other applicable insurance laws. The Life, Accident and Health Insurance Policy Language Simplification Act is not intended to impede flexibility and innovation in the development of policy forms or content, or to lead to the standardization of policy forms or content.

Added by Laws 1986, c. 141, § 2, eff. Jan. 1, 1987.

§36-3643. Definitions.

As used in the Life, Accident and Health Insurance Policy Language Simplification Act:

1. "Policy" or "policy form" means any policy, contract, plan or agreement of life insurance, health and accident insurance, or subscriber certificates of medical care corporations, health care corporations, hospital service associations, or health care maintenance organizations, delivered or issued for delivery in this state by any company subject to the Life, Accident and Health Insurance Policy Language Simplification Act; any certificate, contract or policy issued by a fraternal benefit society; any certificate issued pursuant to a group insurance policy delivered or issued for delivery in this state; and any evidence of coverage issued by a health maintenance organization.

2. "Company" or "insurer" means any entity authorized to do the business of life insurance, accident and health insurance; a fraternal benefit society; a medical care corporation; a health care corporation; a hospital service association; or a health maintenance organization.

Added by Laws 1986, c. 141, § 3, eff. Jan. 1, 1987.

§36-3644. Application of act - Exemptions.

A. The Life, Accident and Health Insurance Policy Language Simplification Act shall apply to all policies delivered or issued for delivery in this state by any company on or after the date such forms must be approved, except:

1. any policy which is a security subject to federal jurisdiction;

2. any group annuity contract which serves as a funding mechanism for pension, profit sharing, or deferred compensation plans;

3. any form used in connection with, as a conversion from, as an addition to, or in exchange pursuant to a contractual provision for, a policy delivered or issued for delivery on a form approved or permitted to be issued prior to January 1, 1990;

4. the renewal of a policy delivered or issued for delivery prior to January 1, 1990; or

5. any group policy covering a group of one thousand or more lives at the date of issue, other than a group credit life insurance policy or a group credit health insurance policy; however, this shall not exempt any certificate issued pursuant to a group policy delivered or issued for delivery in this state.

B. Any non-English language policy delivered or issued for delivery in this state shall be deemed to be in compliance with the Life, Accident and Health Insurance Policy Language Simplification Act if the insurer certifies that such policy is translated from an English language policy which does comply with said act.

Added by Laws 1986, c. 141, § 4, eff. Jan. 1, 1987.

§36-3645. Requirement to be included in life, accident and health insurance policies.

A. No policy forms, unless exempt from the provisions of the Life, Accident and Health Insurance Policy Language Simplification Act, shall be delivered or issued for delivery in this state on or after January 1, 1992, unless:

1. The text achieves a minimum score of forty on the Flesch reading ease test, or an equivalent score on any other comparable test which is recognized as a standard test for determining readability and which is approved by the Commissioner pursuant to subsection C of this section;

2. It is printed, except for specification pages, schedules, and tables, in not less than ten-point type, one-point leaded;

3. The style, arrangement, and overall appearance of the policy give no undue prominence to any portion of the text of the policy, or to any endorsements or riders of the policy;

4. It contains a table of contents or an index of the principal sections of the policy, if the policy has more than three thousand words printed on three or fewer pages of text, or if the policy has more than three pages regardless of the number of words.

B. For the purposes of this section, a Flesch reading ease test score shall be measured by the following method:

1. For policy forms containing ten thousand words or less of text, the entire form shall be analyzed. For policy forms containing more than ten thousand words, the readability of two-hundred-word samples per page may be analyzed instead of the entire form. The samples shall be separated by at least twenty printed lines.

2. The number of words and sentences in the text shall be counted and the total number of words divided by the total number of sentences. The figure obtained shall be multiplied by a factor of one and fifteen-thousandths.

3. The total number of syllables shall be counted and divided by the total number of words. The figure obtained shall be multiplied by a factor of eighty-four and six-tenths.

4. The sum of the figures computed pursuant to paragraphs 2 and 3 of this subsection subtracted from two hundred six and eight hundred thirty-five-thousandths equals the Flesch reading ease score for the policy form.

5. For purposes of paragraphs 2, 3 and 4 of this subsection, the following procedures shall be used:

a. A contraction, hyphenated word, or numbers and letters, when separated by spaces, shall be counted as one word.

b. A unit of words ending with a period, semicolon, or colon, but excluding headings and captions, shall be counted as a sentence.

c. A syllable means a unit of spoken language consisting of one or more letters of a word as divided by an accepted dictionary. Where the dictionary shows two or more equally acceptable pronunciations of a word, the pronunciation containing fewer syllables may be used.

6. As used in this section, "text" includes all printed matter, except the following:

a. The name and address of the insurer, the name, number, or title to the policy, the table of contents or index, captions and subcaptions, specification pages, schedules, or tables;

b. Any policy language that is drafted to conform to the requirements of any federal law, regulation, or agency interpretation; any policy language required by a collectively bargained agreement; any medical terminology; any words that are defined in the policy; and any policy language required by state law or regulation, if the insurer identifies the language or terminology excepted by this paragraph and certifies, in writing, that the language or terminology is drafted to conform with said requirements.

C. Any other reading test may be approved by the Commissioner for use as an alternative to the Flesch reading ease test if it is comparable in result to the Flesch reading ease test.

D. Every filing subject to this section shall be accompanied by a certificate signed by an officer of the insurer stating that the filing meets the minimum reading ease score on the test used, or stating that the score is lower than the minimum required but should be approved in accordance with Section 7 of this act. To confirm the accuracy of any certification, the Commissioner may require the submission of further information to verify the certification in question.

E. At the option of the insurer, riders, endorsements, applications, and other forms made a part of the policy may be scored as separate forms or as part of the policy with which they may be used.

Added by Laws 1986, c. 141, § 5, eff. Jan. 1, 1987.

§36-3646. Effect on existing laws.

Nothing in the Life, Accident and Health Insurance Policy Language Simplification Act shall be construed to negate any law of this state permitting the issuance of any policy form after it has been on file for the time period specified by state law.

Added by Laws 1986, c. 141, § 6, eff. Jan. 1, 1987.

§36-3647. Authorizing lower score than Flesch reading ease score - Conditions.

The Commissioner may authorize a lower score than the required Flesch reading ease score if, in his discretion, he finds that a lower score meets any of the following conditions:

1. The lower score will provide a more accurate reflection of the readability of a policy form;
2. The lower score is warranted by the nature of a particular policy form or type or class of policy form;
3. The lower score is caused by certain policy language that is drafted to conform to the requirement of any law, rule, or agency interpretation.

Added by Laws 1986, c. 141, § 7, eff. Jan. 1, 1987.

§36-3648. Date for compliance with act.

The provisions of the Life, Accident and Health Insurance Policy Language Simplification Act shall apply to all policy forms subject to said act filed on or after January 1, 1990, and no policy form shall be delivered or issued for delivery in this state on or after January 1, 1992, unless approved by the Commissioner or otherwise permitted to be issued. Any policy form that has been approved or permitted to be issued prior to January 1, 1992, that meets the standards established need not be refiled for approval, but may

continue to be lawfully delivered or issued for delivery in this state upon the filing with the Commissioner of a list of such forms identified by form number and accompanied by a certificate which may list all forms submitted concurrently in the manner provided in subsection D of Section 3645 of this title.
Added by Laws 1986, c. 141, § 8, eff. Jan. 1, 1987. Amended by Laws 1986, c. 251, § 41, eff. Nov. 1, 1986.

§36-3649. Violations - Penalties.

Violation of any provision of the Life, Accident and Health Insurance Policy Language Simplification Act may result in censure of the insurer, corporation or organization found to be in violation, suspension or revocation of the certificate or license of said insurer, corporation, or organization, or a fine of not more than One Thousand Dollars (\$1,000.00) per incident, or any combination of such penalties.
Added by Laws 1986, c. 141, § 9, eff. Jan. 1, 1987.

§36-3651. "Actual charge" and "actual fee" defined - Application.

A. As used in an individual or group specified disease insurance policy, "actual charge" or "actual fee" means the amount actually paid by or on behalf of the insured and accepted by a provider for services provided. Insurance policies that use these terms must use them as defined in this section.

B. Except as provided by subsection C of this section, the change in law made by this section applies only to insurance policies delivered, issued for delivery, or renewed on or after the effective date of this act. An insurance policy delivered, issued for delivery, or renewed before the effective date of this act is governed by the law in effect immediately before that date, and that law is continued in effect for that purpose.

C. This section applies to an insurance policy in effect on the effective date of this act only if the policy does not define "actual charge" or "actual fee".
Added by Laws 2006, c. 164, § 1, eff. Nov. 1, 2006.

§36-4001. Scope of article.

This article applies to contracts of life insurance and annuities, other than reinsurance, group life insurance, group annuities, and industrial life insurance; except that Section 2 of this act (Return of policy within ten days), Section 3 of this act (Interest on proceeds), and Sections 4015 (Excluded or restricted coverage), 4024 (Limitation of liability), 4025 (Incontestability after reinstatement), 4028 (Dual or multiple pay policies prohibited) and 4029 (Nonforfeiture provisions) of this article shall apply to industrial life insurance also.

Added by Laws 1957, p. 371, § 4001, operative July 1, 1957. Amended by Laws 1978, c. 162, § 1, eff. Oct. 1, 1978.

§36-4002. Standard provisions required in life insurance policies.

A. No policy of life insurance other than industrial, group, and pure endowments with or without return of premiums or of premiums and interest, shall be delivered or issued for delivery in Oklahoma unless it contains in substance all of the provisions required by Sections 4003 to 4014, inclusive, of this article. This section shall not apply to annuity contracts nor to any provision of a life insurance policy relating to disability benefits or to additional benefits in the event of death by accident or accidental means.

B. Any of such provisions or portions thereof not applicable to single premium or term policies shall to that extent not be incorporated therein.

Laws 1957, p. 371, § 4002.

§36-4003. Grace period.

There shall be a provision that a grace period of thirty (30) days, or, at the option of the insurer, of one month of not less than thirty (30) days, shall be allowed within which the payment of any premium after the first may be made, during which period of grace the policy shall continue in full force; but if a claim arises under the policy during such period of grace before the overdue premium is paid the amount of such premium may be deducted from the policy proceeds.

Laws 1957, p. 371, § 4003.

§36-4003.1. Cancellation of policy - Time period.

A. No policy of individual life insurance or any annuity shall be delivered or issued for delivery in this state unless it shall have printed thereon or attached thereto a notice stating in substance that, during a period of ten (10) days from the date the policy or annuity is delivered to the insured, it may be surrendered to the insurer together with a written request for cancellation of the policy or annuity and, in such event, the policy or annuity shall be void from the beginning and the insurer will refund any premium or moneys paid therefor within thirty (30) days from the date of cancellation. If the insurer does not return any premiums or moneys paid therefor within thirty (30) days from the date of cancellation, the insurer shall pay interest on the proceeds which shall be the same rate of interest as the average United States Treasury Bill rate of the preceding calendar year, as certified to the Insurance Commissioner by the State Treasurer on the first regular business day in January of each year, plus two (2) percentage points, which shall accrue from the date of cancellation

until the premiums or moneys are returned. In such event, the policy or annuity shall be deemed to have been canceled on the date the policy was placed in the U.S. mails in a properly addressed, postpaid envelope; or, if not so posted, on the date of delivery of such policy or annuity to the insurer.

B. This section shall not apply to life insurance policies issued in connection with a credit transaction or issued under a contractual policy change or conversion privilege provision contained in the policy.

Added by Laws 1978, c. 162, § 2, eff. Oct. 1, 1978. Amended by Laws 1984, c. 149, § 13, eff. Nov. 1, 1984; Laws 1994, c. 294, § 6, eff. Sept. 1, 1994.

§36-4004. Incontestability.

There shall be a provision that the policy (exclusive of provisions relating to disability benefits or to additional benefits in the event of death by accident or accidental means) shall be incontestable, except for nonpayment of premiums, after it has been in force during the lifetime of the insured for a period of two (2) years from its date of issue.

Laws 1957, p. 371, § 4004.

§36-4005. Application and policy as entire contract; statements in application as representations.

There shall be a provision that the policy, or the policy and the application therefor if a copy of such application is endorsed upon or attached to the policy when issued, shall constitute the entire contract between the parties, and that all statements contained in the application shall, in the absence of fraud, be deemed representations and not warranties.

Laws 1957, p. 371, § 4005.

§36-4006. Misstatement of age.

There shall be a provision that if the age of the insured or any other person whose age is considered in determining the premium has been misstated, any amount payable or benefit accruing under the policy shall be such as the premium would have purchased at the correct age or ages.

Laws 1957, p. 371, § 4006.

§36-4007. Dividends.

There shall be a provision in participating policies that, beginning not later than the end of the third policy year, the insurer shall annually ascertain and apportion the divisible surplus, if any, that will accrue on the policy anniversary or other dividend date specified in the policy provided the policy is in force and all premiums to that date are paid. Except as hereinafter

provided, any dividend so apportioned shall at the option of the party entitled to elect such option be either (a) payable in cash or (b) applied to any one of such other dividend options as may be provided by the policy. If any such other dividend options are provided, the policy shall further state which option shall be automatically effective if such party shall not have elected some other option. If the policy specifies a period within which such other dividend option may be elected, such period shall be not less than thirty (30) days following the date on which such dividend is due and payable. The annually apportioned dividend shall be deemed to be payable in cash within the meaning of (a) above even though the policy provides that payment of such dividend is to be deferred for a specified period, provided such period does not exceed six (6) years from the date of apportionment and that interest will be added to such dividend at a specified rate. If a participating policy provides that the benefit under any paid-up nonforfeiture provision is to be participating, it may provide that any divisible surplus apportioned while the insurance is in force under such nonforfeiture provision shall be applied in the manner set forth in the policy. Laws 1957, p. 371, § 4007.

§36-4008. Policy loan.

A. There shall be a provision that after three (3) full years' premiums have been paid, the insurer, at any time while the policy is in force, will loan on the execution of a proper note or loan agreement by the owner of the policy, and on proper assignment of the policy and on the sole security thereof, at a specified rate of interest, not in excess of six percent (6%) per annum, on policies issued prior to January 1, 1976, a sum equal to or, at the option of the owner of the policy, less than the cash value of the policy at the end of the current policy year and of any dividend additions thereto. A policy issued on or after such date and prior to July 1, 1982, shall contain either, but not both, of the following policy loan interest rate provisions:

1. A provision that a policy loan shall bear interest at a specified rate, not in excess of eight percent (8%) per annum; or
2. A provision that all loans under the policy shall bear interest at a variable rate, not in excess of eight percent (8%) per annum, specified from time to time by the insurer. The effective date of any increase in such variable rate shall not be less than one (1) year after the effective date of the previous rate.

B. With respect to policies providing for a variable rate, the insurer shall:

1. When a loan is made and when notification of interest due is furnished, give notice of the variable rate currently effective;
2. As to any loans outstanding forty (40) days before the effective date of any increase in the variable rate, give notice of

any such increase at least thirty (30) days before such effective date; and

3. As to any loans made during the forty (40) days before the effective date of this increase, give notice of such increase when the loan is made.

Every such notice shall be given as directed by the policy owner and any assignee as shown on the records of the insurer at its home office.

C. With respect to policies issued on or after July 1, 1982, the following provisions shall apply:

1. For purposes of this subsection, the "Published Monthly Average" means:

a. Moody's Corporate Bond Yield Average - Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto, or

b. in the event that Moody's Corporate Bond Yield Average - Monthly Average Corporates is no longer published, a substantially similar average, established by regulation issued by the Commissioner;

2. Policies issued on or after July 1, 1982, shall provide for policy loan interest rates as follows:

a. a provision permitting a maximum interest rate of not more than eight percent (8%) per annum, or

b. a provision permitting an adjustable maximum interest rate established from time to time by the life insurer as permitted by law;

3. The rate of interest charged on a policy loan made under subparagraph b of paragraph 2 of this subsection shall not exceed the higher of the following:

a. the Published Monthly Average for the calendar month ending two (2) months before the date on which the rate is determined, or

b. the rate used to compute the cash surrender values under the policy during the applicable period plus one percent (1%) per annum;

4. If the maximum rate of interest is determined pursuant to subparagraph b of paragraph 2 of this subsection, the policy shall contain a provision setting forth the frequency at which time the rate is to be determined for that policy;

5. The maximum rate for each policy must be determined at regular intervals at least once every twelve (12) months, but not more frequently than once in any three-month period. At the intervals specified in the policy:

a. the rate being charged may be increased whenever such increase as determined under paragraph 3 of this subsection would increase that rate by one-half of one percent (1/2 of 1%) or more per annum, or

b. the rate being charged must be reduced whenever such reduction as determined under paragraph 3 of this subsection would decrease that rate by one-half of one percent (1/2 of 1%) or more per annum;

6. The life insurer shall:

a. notify the policyholder at the time a cash loan is made of the initial rate of interest on the loan,

b. notify the policyholder with respect to premium loans of the initial rate of interest on the loan as soon as it is reasonably practical to do so after making the initial loan. Notice need not be given to the policyholder when a further premium loan is added, except as provided in subparagraph c below,

c. send to policyholders with loans reasonable advance notice of any increase in the rate, and

d. include in the notices required above, the substance of the pertinent provisions of paragraphs 2 and 4 of this subsection;

7. The loan value of the policy shall be determined in accordance with Section 4029 of this title, but no policy shall terminate in a policy year as the sole result of a change in the interest rate during that policy year, and the life insurer shall maintain coverage during that policy year until the time at which the policy would otherwise have terminated if there had been no change during that policy year;

8. The substance of the pertinent provisions of paragraphs 2 and 4 of this subsection shall be set forth in the policies to which they apply;

9. For purposes of this subsection:

a. the rate of interest on policy loans permitted under this subsection includes the interest rate charged on reinstatement of policy loans for the period during and after any lapse of a policy,

b. the term "policy loan" includes any premium loan made under a policy to pay one or more premiums that were not paid to the life insurer as they fell due,

c. the term "policyholder" includes the owner of the policy or the person designated to pay premiums as shown on the records of the life insurer, and

d. the term "policy" includes certificates issued by a fraternal benefit society and annuity contracts which provide for policy loans;

10. No other provision of law shall apply to policy loan interest rates unless made specifically applicable to such rates; and

11. The provisions of this act shall not apply to any insurance contract issued before the effective date of this act

unless the policyholder agrees in writing to the applicability of such provisions.

D. The company may deduct from such loan value any existing indebtedness on or secured by the policy not already deducted in determining such cash value including interest due or accrued, and any unpaid balance of the premium for the current policy year, and any interest which may be allowable on the loan to the end of the current policy year; provided, that the policy shall reserve to the insurer the right to defer the granting of a loan, other than for the payment of any premium to the insurer, for six (6) months after the application therefor is made. The policy may also provide that if interest on any indebtedness is not paid when due it shall then be added to the existing indebtedness and shall bear interest at the same rate, and that if and when the total indebtedness on the policy, including interest due or accrued, equals or exceeds the amount of the loan value thereof, then the policy shall terminate and become void, but not until at least thirty (30) days' notice shall have been mailed by the insurer to the last-known address of the insured or policy owner and of any assignee of record at the home office of the insurer.

The policy, at the insurer's option, may provide for an automatic premium loan, subject to an election of the party entitled to elect. No condition other than as herein provided shall be exacted as a prerequisite to any such loan. This provision shall not be required in term insurance, nor shall it apply to temporary insurance or pure endowment insurance, issued or granted in exchange for lapsed or surrendered policies.

Amended by Laws 1982, c. 139, § 1, eff. July 1, 1982.

§36-4009. Nonforfeiture benefits.

There shall be provisions for nonforfeiture benefits and cash surrender values as required by Section 4029 of this article. Laws 1957, p. 372, § 4009.

§36-4010. Table of installments.

There shall be a table showing the amount of installments in which the policy may provide its proceeds may be payable. Laws 1957, p. 372, § 4010.

§36-4011. Reinstatement.

There shall be a provision that unless the policy has been surrendered for its cash surrender value or unless the paid-up term insurance, if any, has expired, the policy will be reinstated at any time within three (3) years from the date of premium default upon written application therefor, the production of evidence of insurability satisfactory to the insurer, the payment of all premiums in arrears, with interest at a rate not exceeding six

percent (6%) compounded annually, and the payment or reinstatement of any other indebtedness to the insurer upon the policy, with compound interest at the interest rate or rates which apply to policy loans between the due date of the premium first in default and the date of reinstatement.

Amended by Laws 1984, c. 149, § 14, eff. Nov. 1, 1984.

§36-4012. Payment of premiums.

There shall be a provision that all premiums after the first shall be payable in advance, either at the home office of the company or to an agent of the company, upon the delivery of a receipt signed by one or more of the officers who shall be designated in the policy.

Laws 1957, p. 372, § 4012.

§36-4013. Payment of claims.

There shall be a provision that when a policy shall become a claim by the death of the insured settlement shall be made upon receipt of due proof of death and, at the insurer's option, surrender of the policy and/or proof of the interest of the claimant. If an insurer shall specify a particular period prior to the expiration of which settlement shall be made, such period shall not exceed two months from the receipt of such proofs.

Laws 1957, p. 373, § 4013.

§36-4014. Policy title.

There shall be a title on the face and on the back of the policy, briefly describing the same.

Laws 1957, p. 373, § 4014.

§36-4015. Excluded or restricted coverage.

A clause in any policy of life insurance providing that such policy shall be incontestable after a specified period shall preclude only a contest of the validity of the policy, and shall not preclude the assertion at any time of defenses based upon provisions in the policy which exclude or restrict coverage, whether or not such restrictions or exclusions are excepted in such clause; nor shall it be construed to preclude adjustment at any time of the amount payable or benefits accruing under the policy for misstatement of age, whether or not such age adjustment provision is excepted in such clause.

Laws 1957, p. 373, § 4015.

§36-4016. Standard provisions required in annuity and pure endowment contracts.

A. No annuity or pure endowment contract, other than reversionary annuities, survivorship annuities or group annuities

and except as stated herein, shall be delivered or issued for delivery in this state unless it contains in substance each of the provisions specified in Sections 4017 to 4022, inclusive, of this article. Any of such provisions not applicable to single premium annuities or single premium pure endowment contracts shall not, to that extent, be incorporated therein.

B. This section shall not apply to contracts for deferred annuities included in, or upon the lives of beneficiaries under, life insurance policies.

Laws 1957, p. 373, § 4016.

§36-4017. Grace period; annuities.

In an annuity or pure endowment contract, other than a reversionary, survivorship or group annuity, there shall be a provision that there shall be a period of grace of one (1) month, but not less than thirty (30) days, within which any stipulated payment to the insurer falling due after the first may be made, subject at the option of the insurer to an interest charge thereon at a rate to be specified in the contract but not exceeding six percent (6%) per annum for the number of days of grace elapsing before such payment, during which period of grace the contract shall continue in full force; but in case a claim arises under the contract on account of death prior to expiration of the period of grace before the overdue payment to the insurer or the deferred payments of the current contract year, if any, are made, the amount of such payments, with interest on any overdue payments, may be deducted from any amount payable under the contract in settlement.

Laws 1957, p. 373, § 4017.

§36-4018. Incontestability; annuities.

If any statements, other than those relating to age, sex and identity are required as a condition to issuing an annuity or pure endowment contract, other than a reversionary, survivorship, or group annuity, and subject to Section 4020 of this article, there shall be a provision that the contract shall be incontestable after it has been in force during the lifetime of the person or of each of the persons as to whom such statements are required, for a period of two (2) years from its date of issue, except for nonpayment of stipulated payments to the insurer; and at the option of the insurer such contract may also except any provisions relative to benefits in the event of disability and any provisions which grant insurance specifically against death by accident or accidental means.

Laws 1957, p. 373, § 4018.

§36-4019. Application and contract as entire contract in annuities.

In an annuity or pure endowment contract, other than a reversionary, survivorship or group annuity, there shall be a

provision that the contract shall constitute the entire contract between the parties or, if a copy of the application is endorsed upon or attached to the contract when issued, a provision that the contract and the application therefor shall constitute the entire contract between the parties.

Laws 1957, p. 374, § 4019.

§36-4020. Misstatement of age; annuities.

In an annuity or pure endowment contract, other than a reversionary, survivorship, or group annuity, there shall be a provision that if the age of the person or persons upon whose life or lives the contract is made, or any of them, has been misstated, the amount payable or benefits accruing under the contract shall be such as the stipulated payment or payments to the insurer would have purchased according to the correct age; and that if the insurer shall make or has made any overpayment or overpayments on account of any such misstatement, the amount thereof, with interest at the rate to be specified in the contract but not exceeding six percent (6%) per annum, may be charged against the current or next succeeding payment or payments to be made by the insurer under the contract.

Laws 1957, p. 374, § 4020.

§36-4021. Dividends on annuities.

If an annuity or pure endowment contract, other than a reversionary, survivorship, or group annuity, is participating, there shall be a provision that the insurer shall annually ascertain and apportion any divisible surplus accruing on the contract.

Laws 1957, p. 374, § 4021.

§36-4022. Reinstatement of annuities.

In an annuity or pure endowment contract, other than a reversionary, survivorship, or group annuity, there shall be a provision that the contract may be reinstated at any time within one (1) year from the default in making stipulated payments to the insurer, unless the cash surrender value has been paid, but all overdue stipulated payments and any indebtedness to the insurer on the contract shall be paid or reinstated with interest thereon at a rate to be specified in the contract but not exceeding six percent (6%) per annum payable annually, and in cases where applicable the insurer may also include a requirement of evidence of insurability satisfactory to the insurer.

Laws 1957, p. 374, § 4022.

§36-4023. Standard provisions required in reversionary annuities.

A. Except as stated herein, no contract for a reversionary annuity shall be delivered or issued for delivery in this state unless it contains in substance each of the following provisions:

1. Any such reversionary annuity contract shall contain the provisions specified in Sections 4017, 4018, 4019, 4021 and 4022 of this article, except that under said Section 4017 the insurer may at its option provide for an equitable reduction of the amount of the annuity payments in settlement of an overdue or deferred payment in lieu of providing for deduction of such payments from an amount payable upon settlement under the contract.

2. In such reversionary annuity contracts there shall be a provision that the contract may be reinstated at any time within three (3) years from the date of default in making stipulated payments to the insurer, upon production of evidence of insurability satisfactory to the insurer, and upon condition that all overdue payments and any indebtedness to the insurer on account of the contract be paid, or, within the limits permitted by the then cash values of the contract, reinstated, with interest as to both payments and indebtedness at a rate to be specified in the contract but not exceeding six percent (6%) per annum compounded annually.

B. This section shall not apply to group annuities or to annuities included in life insurance policies, and any of such provisions not applicable to single premium annuities shall not to that extent be incorporated therein.

Laws 1957, p. 374, § 4023.

§36-4024. Limit of liability - Life insurance policy application denial.

A. No policy of life insurance shall be delivered or issued for delivery in this state if it contains a provision which excludes or restricts liability for death caused in a certain specified manner or occurring while the insured has a specified status, except that a policy may contain provisions excluding or restricting coverage as specified therein in the event of death under any one or more of the following circumstances:

1. Death as a result of a declared war or military action.

2. Death resulting from violations of the conditions of the policy relating to service, travel, or flight in any species of aircraft, other than as a fare-paying passenger in a licensed passenger aircraft, piloted by a licensed passenger pilot on a regular passenger route between definitely established airports.

3. Death within two (2) years from the date of issue of the policy as a result of suicide, while sane or insane; provided, that in the event of death as a result of suicide within two (2) years from the date of issue of the policy the insurer shall return the amount of all premiums paid.

B. A policy which contains any exclusion or restriction pursuant to paragraphs 1 and 2 of subsection A of this section shall also provide that in the event of death under the circumstances to which any such exclusion or restriction is applicable, the insurer

will pay an amount not less than a reserve determined according to the reserve valuation method and upon the basis of the mortality table and interest rate specified in the policy for the calculation of nonforfeiture benefits (or if the policy provides for no such benefits, computed according to a mortality table and interest rate determined by the insurer and specified in the policy) with adjustment for indebtedness or dividend credit.

C. A life insurance company doing business within this state shall not deny or refuse to accept an application for life insurance or refuse to renew, cancel, restrict, or otherwise terminate a policy of life insurance, or charge a different rate for the same life insurance coverage, based upon the lawful travel destinations of the applicant or the insured. Nothing in this subsection shall prohibit a life insurance company from denying an application for life insurance, or restricting or charging a different premium or rate for coverage under such a policy based on a specific travel destination where the denial, restriction, or rate differential is based upon sound actuarial principles or is related to actual or anticipated experience. A violation of this subsection shall be an unfair trade practice pursuant to Section 1250.5 of this title. The provisions of this subsection shall apply to any life insurance policy issued on or after the effective date of this act.

D. This section shall not apply to group life insurance, accident and health insurance, reinsurance, or annuities, or to any provision in a life insurance policy relating to disability benefits or to additional benefits in the event of death by accident or accidental means, except as provided in subsection C of this section.

Added by Laws 1957, p. 374, § 4024. Amended by Laws 2012, c. 105, § 2.

§36-4025. Incontestability after reinstatement.

The reinstatement of any policy of life insurance or annuity contract hereafter delivered or issued for delivery in this state may be contested on account of fraud or misrepresentation of facts material to the reinstatement only for the same period following reinstatement and with the same conditions and exceptions as the policy provides with respect to contestability after original issuance.

Laws 1957, p. 375, § 4025.

§36-4026. Policy settlements.

Any life insurer shall have the power to hold under agreement the proceeds of any policy issued by it, upon such terms and restrictions as to revocation by the policyholder and control by beneficiaries, and with such exemptions from the claims of creditors of beneficiaries other than the policyholder as set forth in the

policy or as agreed to in writing by the insurer and the policyholder. Upon maturity of a policy, in the event the policyholder has made no such agreement, the insurer shall have the power to hold the proceeds of the policy under an agreement with the beneficiaries. The insurer shall not be required to segregate the funds so held but may hold them as part of its general assets. Laws 1957, p. 375, § 4026.

§36-4027. Authorized deductions from insurance proceeds.

In determining the amount due under any life insurance policy heretofore or hereafter issued, deduction may be made of:

1. Any unpaid premiums or instalments thereof for the current policy year due under the terms of the policy, and of

2. The amount of principal and accrued interest of any policy loan or other indebtedness against the policy then remaining unpaid. Laws 1957, p. 375, § 4027.

§36-4028. Dual or multiple pay policies prohibited.

No life insurance policy shall be issued or delivered in this state if it provides that, on the death of anyone not specifically named therein, other than a beneficiary, the owner or beneficiary of the policy shall receive the payment or granting of anything of value.

Laws 1957, p. 375, § 4028.

§36-4029. Operative date of valuation manual - Nonforfeiture provisions - Life insurance.

A. Definitions. The term "operative date of the valuation manual" means the January 1 of the first calendar year that the valuation manual, as defined in the Section 1510 of this title, is effective.

B. No policy of life insurance, except as set forth in subsection M of this section, shall be delivered or issued for delivery in this state unless it shall contain in substance the following provisions, or corresponding provisions which are at least as favorable to the defaulting or surrendering policyholder as are the minimum requirements hereinafter specified and are essentially in compliance with subsection L of this section:

1. That in the event of default in any premium payment, after premiums have been paid for at least three (3) full years, the insurer will grant, upon proper request not later than sixty (60) days after the due date of the premium in default, a paid-up nonforfeiture benefit on a plan stipulated in the policy, effective as of such due date, of such amount as may be hereinafter specified. In lieu of such stipulated paid-up nonforfeiture benefit, the insurer may substitute, upon proper request not later than sixty (60) days after the due date of the premium in default, an

actuarially equivalent alternative paid-up nonforfeiture benefit which provides a greater amount or longer period of death benefits or, if applicable, a greater amount or earlier payment of endowment benefits.

2. That upon surrender of the policy within sixty (60) days after the due date of any premium payment in default after premiums have been paid for at least three (3) full years in the case of ordinary insurance, or five (5) full years in the case of industrial insurance, the insurer will pay, in lieu of any paid-up nonforfeiture benefit, a cash surrender value of such amount as may be hereinafter specified.

3. That a specified paid-up nonforfeiture benefit shall become effective as specified in the policy unless the person entitled to make such election elects another available option not later than sixty (60) days after the due date of the premium in default.

4. That if the policy shall have become paid up by completion of all premium payments, or if it is continued under any paid-up nonforfeiture benefit which became effective on or after the third policy anniversary in the case of ordinary insurance, or the fifth policy anniversary in the case of industrial insurance, the insurer will pay, upon surrender of the policy within thirty (30) days after any policy anniversary, a cash surrender value of such amount as may be hereinafter specified.

5. In the case of policies which cause, on a basis guaranteed in the policy, unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than a change to a new policy, a statement of the mortality table, interest rate and method used in calculating cash surrender values and the paid-up nonforfeiture benefits available under the policy. In the case of all other policies, a statement of the mortality table and interest rate used in calculating the cash surrender values and the paid-up nonforfeiture benefits available under the policy, together with a table showing the cash surrender value, if any, and paid-up nonforfeiture benefit, if any, available under the policy on each policy anniversary, either during the first twenty (20) policy years or during the term of the policy, whichever is shorter, such values and benefits to be calculated upon the assumption that there are no dividends or paid-up additions credited to the policy and that there is no indebtedness to the insurer on the policy.

6. An explanation of the manner in which the cash surrender values and the paid-up nonforfeiture benefits are altered by the existence of any paid-up additions credited to the policy or any indebtedness to the insurer on the policy; if a detailed statement of the method of computation of the values and benefits shown in the policy is not stated therein, a statement that such method of computation has been filed with the insurance supervisory official of the state in which the policy is delivered; and a statement of

the method to be used in calculating the cash surrender value and paid-up nonforfeiture benefit available under the policy on any policy anniversary beyond the last anniversary for which such values and benefits are consecutively shown in the policy.

C. Any of the provisions or portions thereof set forth in paragraphs 1 through 6 of subsection B of this section which are not applicable by reason of the plan of insurance may, to the extent inapplicable, be omitted from the policy. The insurer shall reserve the right to defer the payment of any cash surrender value for a period of six (6) months after demand therefor with surrender of the policy.

D. Cash surrender value: The policy must comply with the requirements of one of the following paragraphs:

1. Any cash surrender value available under the policy in the event of default in the premium payment due on any policy anniversary, whether or not required by subsection B of this section, shall be at least equal to the reserve on the policy at date of default and on any paid-up additions thereto, less a sum of not more than two and one-half percent (2 1/2%) of the amount insured by the policy and of the paid-up additions thereto, if any, and less any existing indebtedness to the company on or secured by the policy; the reserve on such policy to be computed in accordance with the mortality table and the rate of interest specified in the policy for the calculation of the cash value and by the net level premium method of valuation unless a modified net premium method of valuation be specified in the policy. No cash surrender value shall be required in policies of term insurance of twenty (20) years or less.

2. Any cash surrender value available under the policy in the event of default in the premium payment due on any policy anniversary, whether or not required by subsection B of this section, shall be an amount not less than the excess, if any, of the present value on such anniversary of the future guaranteed benefits which would have been provided for by the policy, including any existing paid-up additions if there had been no default over the sum of (i) the then present value of the adjusted premiums as defined in subsections G, H and I of this section, corresponding to premiums which would have fallen due on and after such anniversary, and (ii) the amount of any indebtedness to the insurer on account of or secured by the policy.

3. Provided, however, that for any policy issued on or after the operative date of paragraph 4 of subsection I of this section as defined therein, which provides supplemental life insurance or annuity benefits at the option of the insured and for an identifiable additional premium by rider or supplemental policy provision, the cash surrender value referred to in paragraph 2 of this subsection shall be an amount not less than the sum of the cash

surrender value as defined in such paragraph for an otherwise similar policy issued at the same age without such rider or supplemental policy provision and the cash surrender value as defined in such paragraph for a policy which provides only the benefits otherwise provided by such rider or supplemental policy provision.

4. Provided, further, that for any family policy issued on or after the operative date of paragraph 4 of subsection I of this section as defined therein, which defines a primary insured and provides term insurance on the life of the spouse of the primary insured expiring before the spouse's age seventy-one (71) years, the cash surrender value referred to in paragraph 2 of this subsection shall be an amount not less than the sum of the cash surrender value as defined in such paragraph for an otherwise similar policy issued at the same age without such term insurance on the life of the spouse and the cash surrender value as defined in such paragraph for a policy which provides only the benefits otherwise provided by such term insurance on the life of the spouse.

5. Any cash surrender value available within thirty (30) days after any policy anniversary under any policy paid up by completion of all premium payments, or any policy continued under any paid-up nonforfeiture benefits, whether or not required by subsection B, shall be an amount not less than the present value, on such anniversary, of the future guaranteed benefits provided for by the policy including any existing paid-up additions, decreased by any indebtedness to the insurer on account of or secured by the policy. The method described in paragraphs 2, 3, 4 and 5 of this subsection may be referred to as the Standard Nonforfeiture Value Method.

E. Notification to policyholder of cash surrender value: Within three (3) months after default of any premium payment on any life insurance policy which has a cash surrender value, the insurer shall notify the policyholder in writing of the cash surrender value and of the policyholder's options as to the application of the cash surrender value as provided in the policy.

F. Paid-up nonforfeiture benefits: Any paid-up nonforfeiture benefit available under the policy in the event of default in the premium payment due on any policy anniversary shall be such that its present value as of such anniversary shall be at least equal to the cash surrender value then provided for by the policy, or, if none is provided for, that cash surrender value which would have been required by this section in the absence of the condition that premiums shall have been paid for at least a specified period.

G. The adjusted premium: This subsection shall not apply to policies issued on or after the operative date of paragraph 4 of subsection I of this section as defined therein. Except as provided in paragraph 2 of subsection H of this section, the adjusted premiums for any policy shall be calculated on an annual basis and

shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding extra premiums on a substandard policy, that the present value, at the date of issue of the policy, of all such adjusted premiums shall be equal to the sum of:

- (i) the then present value of the future guaranteed benefits provided for by the policy;
- (ii) two percent (2%) of the amount of the insurance if the insurance be uniform in amount, or of the equivalent uniform amount, as hereinafter defined, if the amount of insurance varies with the duration of the policy;
- (iii) forty percent (40%) of the adjusted premium for the first policy year; and
- (iv) twenty-five percent (25%) of either the adjusted premium for the first policy year or the adjusted premium for a whole life policy of the same uniform or equivalent uniform amount with uniform premiums for the whole of life issued at the same age for the same amount of insurance, whichever is less, provided, however, that in applying the percentages specified in clauses (iii) and (iv) above, no adjusted premiums shall be deemed to exceed four percent (4%) of the amount of insurance or uniform amount equivalent thereto.

The date of issue of a policy for the purpose of this section shall be the date as of which the rated age of the insured is determined.

H. 1. This subsection shall not apply to policies issued on or after the operative date of paragraph 4 of subsection I of this section as defined therein. In the case of a policy providing an amount of insurance varying with the duration of the policy, the equivalent uniform amount thereof for the purpose of subsection G of this section shall be deemed to be the uniform amount of insurance provided by an otherwise similar policy, containing the same endowment benefit or benefits, if any, issued at the same age and for the same term, the amount of which does not vary with duration and the benefits under which have the same present value at the date of issue as the benefits under the policy, provided, however, that in the case of a policy providing a varying amount of insurance issued on the life of a child under age ten (10) years, the equivalent uniform amount may be computed as though the amount of insurance provided by the policy prior to the attainment of age ten (10) years were the amount provided by such policy at age ten (10) years.

2. The adjusted premiums for any policy providing term insurance benefits by rider or supplemental policy provision shall be equal to (a) the adjusted premiums for an otherwise similar

policy issued at the same age without such term insurance benefits, increased, during the period for which premiums for such term insurance benefits are payable, by (b) the adjusted premiums for such term insurance, the foregoing items (a) and (b) being calculated separately and as specified in subsection G of this section and paragraph 1 of this subsection except that, for the purposes of clauses (ii), (iii) and (iv) of subsection G of this section, the amount of insurance or equivalent uniform amount of insurance used in the calculation of the adjusted premiums referred to in (b) shall be equal to the excess of the corresponding amount determined for the entire policy over the amount used in the calculation of the adjusted premiums in (a).

I. 1. This paragraph shall not apply to policies issued on or after the operative date of paragraph 4 of this subsection as defined therein. For policies which comply with the requirements of paragraph 2 of subsection D of this section and except as otherwise provided in paragraphs 2 and 3 of this subsection, all adjusted premiums and present values referred to in this section shall for policies of ordinary insurance be calculated on the basis of the Commissioners 1941 Standard Ordinary Mortality Table, provided that for any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age not more than three (3) years younger than the actual age of the insured, and such calculations for all policies of industrial insurance shall be made on the basis of the 1941 Standard Industrial Mortality Table. All calculations shall be made on the basis of the rate of interest, not exceeding three and one-half percent (3 1/2%) per annum, specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits, provided, however, that in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than one hundred thirty percent (130%) of the rates of mortality according to such applicable table, provided further that for insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the insurer and approved by the Insurance Commissioner.

2. This paragraph shall not apply to ordinary policies issued on or after the operative date of paragraph 4 of this subsection as defined therein. In the case of ordinary policies which comply with the requirements of paragraph 2 of subsection D of this section issued on or after July 1, 1962, all adjusted premiums and present values referred to in this section may be calculated on the basis of the Commissioners 1958 Standard Ordinary Mortality Table and the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits, provided that

such rate of interest shall not exceed three and one-half percent (3 1/2%) per annum except that a rate of interest not exceeding four percent (4%) per annum may be used for policies issued on or after April 11, 1974, and prior to March 17, 1978, and rate of interest not exceeding five and one-half percent (5 1/2%) per annum may be used for policies issued on or after March 17, 1978, and provided that for any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age not more than six (6) years younger than the actual age of the insured. Provided, however, that in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1958 Extended Term Insurance Table. Provided, further, that for insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the company and approved by the Commissioner.

3. This paragraph shall not apply to industrial policies issued on or after the operative date of paragraph 4 of this subsection as defined therein. In the case of industrial policies, which comply with the requirements of paragraph 2 of subsection D of this section, all adjusted premiums and present values referred to in this section may be calculated on the basis of the Commissioners 1961 Standard Industrial Mortality Table and the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits provided that such rate of interest shall not exceed three and one-half percent (3 1/2%) per annum except that a rate of interest not exceeding four percent (4%) per annum may be used for policies issued on or after April 11, 1974, and prior to March 17, 1978, and a rate of interest not exceeding five and one-half percent (5 1/2%) per annum may be used for policies issued on or after March 17, 1978. Provided, however, that in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1961 Industrial Extended Term Insurance Table. Provided, further, that for insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the company and approved by the Commissioner.

4. (a) This paragraph shall apply to all policies issued on or after the operative date of this paragraph as defined herein. Except as provided in subparagraph (g) of this paragraph, the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective

premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments or special hazards and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the date of issue of the policy, of all adjusted premiums shall be equal to the sum of (i) the then present value of the future guaranteed benefits provided for by the policy; (ii) one percent (1%) of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten (10) policy years; and (iii) one hundred twenty-five percent (125%) of the nonforfeiture net level premium as hereinafter defined. Provided, however, that in applying the percentage specified in (iii) above no nonforfeiture net level premium shall be deemed to exceed four percent (4%) of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten (10) policy years. The date of issue of a policy for the purpose of this paragraph shall be the date as of which the rated age of the insured is determined.

- (b) The nonforfeiture net level premium shall be equal to the present value, at the date of issue of the policy, of the guaranteed benefits provided for by the policy divided by the present value, at the date of issue of the policy, of an annuity of one per annum payable on the date of issue of the policy and on each anniversary of such policy on which a premium falls due.
- (c) In the case of policies which cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than a change to a new policy, the adjusted premiums and present values shall initially be calculated on the assumption that future benefits and premiums do not change from those stipulated at the date of issue of the policy. At the time of any such change in the benefits or premiums the future adjusted premiums, nonforfeiture net level premiums and present values shall be recalculated on the assumption that future benefits and premiums do not change from those stipulated by the policy immediately after the change.

- (d) Except as otherwise provided in subparagraph (g) of this paragraph, the recalculated future adjusted premiums for any such policy shall be such uniform percentage of the respective future premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments and special hazards, and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the time of change to the newly defined benefits or premiums, of all such future adjusted premiums shall be equal to the excess of
- (A) the sum of
 - (i) the then present value of the then future guaranteed benefits provided for by the policy and
 - (ii) the additional expense allowance, if any, over
 - (B) the then cash surrender value, if any, or present value of any paid-up nonforfeiture benefit under the policy.
- (e) The additional expense allowance, at the time of the change to the newly defined benefits or premiums, shall be the sum of
- (i) one percent (1%) of the excess, if positive, of the average amount of insurance at the beginning of each of the first ten (10) policy years subsequent to the change over the average amount of insurance prior to the change at the beginning of each of the first ten (10) policy years subsequent to the time of the most recent previous change, or, if there has been no previous change, the date of issue of the policy; and
 - (ii) one hundred twenty-five percent (125%) of the increase, if positive, in the nonforfeiture net level premium.
- (f) The recalculated nonforfeiture net level premium shall be equal to the result obtained by dividing (A) by (B) where
- (A) equals the sum of
 - (i) the nonforfeiture net level premium applicable prior to the change times the present value of an annuity of one per annum payable on each anniversary of the policy on

or subsequent to the date of the change on which a premium would have fallen due had the change not occurred, and

- (ii) the present value of the increase in future guaranteed benefits provided for by the policy, and
- (B) equals the present value of an annuity of one per annum payable on each anniversary of the policy on or subsequent to the date of change on which a premium falls due.
- (g) Notwithstanding any other provisions of this paragraph to the contrary, in the case of a policy issued on a substandard basis which provides reduced graded amounts of insurance so that, in each policy year, such policy has the same tabular mortality cost as an otherwise similar policy issued on the standard basis which provides higher uniform amounts of insurance, adjusted premiums and present values for such substandard policy may be calculated as if it were issued to provide such higher uniform amounts of insurance on the standard basis.
- (h) All adjusted premiums and present values referred to in this section shall for all policies of ordinary insurance be calculated on the basis of (i) the Commissioners 1980 Standard Ordinary Mortality Table or (ii) at the election of the insurer for any one or more specified plans of life insurance, the Commissioners 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors; shall for all policies of industrial insurance be calculated on the basis of the Commissioners 1961 Standard Industrial Mortality Table; and shall for all policies issued in a particular calendar year be calculated on the basis of a rate of interest not exceeding the nonforfeiture interest rate as defined in this paragraph for policies issued in that calendar year. Provided, however, that:
 - (i) At the option of the insurer, calculations for all policies issued in a particular calendar year may be made on the basis of a rate of interest not exceeding the nonforfeiture interest rate, as defined in this paragraph, for policies issued in the immediately preceding calendar year.
 - (ii) Under any paid-up nonforfeiture benefit, including any paid-up dividend additions, any cash surrender value available, whether or not required by subsection B of this section, shall

- be calculated on the basis of the mortality table and rate of interest used in determining the amount of such paid-up nonforfeiture benefit and paid-up dividend additions, if any.
- (iii) An insurer may calculate the amount of any guaranteed paid-up nonforfeiture benefit including any paid-up additions under the policy on the basis of an interest rate no lower than that specified in the policy for calculating cash surrender values.
 - (iv) In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1980 Extended Term Insurance Table for policies of ordinary insurance and not more than the Commissioners 1961 Industrial Extended Term Insurance Table for policies of industrial insurance.
 - (v) For insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on appropriate modifications of the aforementioned tables.
 - (vi) For policies issued prior to the operative date of the valuation manual, any Commissioners Standard mortality tables, adopted after 1980 by the National Association of Insurance Commissioners, that are approved by regulation promulgated by the Commissioner for use in determining the minimum nonforfeiture standard may be substituted for the Commissioners 1980 Standard Ordinary Mortality Table with or without Ten-Year Select Mortality Factors or for the Commissioners 1980 Extended Term Insurance Table. For policies issued on or after the operative date of the valuation manual, the valuation manual shall provide the Commissioners Standard mortality table for use in determining the minimum nonforfeiture standard that may be substituted for the Commissioners 1980 Standard Ordinary Mortality Table with or without Ten-Year Select Mortality Factors or for the Commissioners 1980 Extended Term Insurance Table. If the commissioner approves by rule any Commissioners Standard mortality table adopted by the National Association of Insurance Commissioners for use in determining the minimum nonforfeiture standard

for policies issued on or after the operative date of the valuation manual then that minimum nonforfeiture standard supersedes the minimum nonforfeiture standard provided by the valuation manual, and

- (vii) For policies issued prior to the operative date of the valuation manual, any Commissioners Standard industrial mortality tables, adopted after 1980 by the National Association of Insurance Commissioners, that are approved by regulation promulgated by the Commissioner for use in determining the minimum nonforfeiture standard may be substituted for the Commissioners 1961 Standard Industrial Mortality Table or the Commissioners 1961 Industrial Extended Term Insurance Table.

For policies issued on or after the operative date of the valuation manual the valuation manual shall provide the Commissioner's Standard mortality table for use in determining the minimum nonforfeiture standard that may be substituted for the Commissioners 1961 Standard Industrial Mortality Table or the Commissioners 1961 Industrial Extended Term Insurance Table. If the commissioner approves by regulation any Commissioner's Standard industrial mortality table adopted by the National Association of Insurance Commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual then that minimum nonforfeiture standard supersedes the minimum nonforfeiture standard provided by the valuation manual.

- (i) The nonforfeiture interest rate is defined below:
 - (i) For policies issued prior to the operative date of valuation manual, the nonforfeiture interest rate per annum for any policy issued in a particular calendar year shall be equal to one hundred twenty-five percent (125%) of the calendar year statutory valuation interest rate for such policy as defined in the Standard Valuation Law, rounded to the nearest one-fourth of one percent ($1/4$ of 1%); provided, however, that the nonforfeiture interest rate shall not be less than four percent (4%), and
 - (ii) For policies issued on and after the operative date of the valuation manual the nonforfeiture

interest rate per annum for any policy issued in a particular calendar year shall be provided by the valuation manual.

- (j) Notwithstanding any other provision in this code to the contrary, any refiling of nonforfeiture values or their methods of computation for any previously approved policy form which involves only a change in the interest rate or mortality table used to compute nonforfeiture values shall not require refiling of any other provisions of that policy form.
- (k) Any insurer may file with the Commissioner a written notice of its election to comply with the provisions of this paragraph after a specified date before January 1, 1989, which specified date shall be the operative date of this paragraph for such insurer. If an insurer makes no such election, the operative date of this paragraph for such insurer shall be January 1, 1989.

J. In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurer based on then estimates of future experience, or in the case of any plan of life insurance which is of such a nature that minimum values cannot be determined by the methods described in subsections B through I of this section:

1. The Commissioner must be satisfied that the benefits provided under the plan are substantially as favorable to policyholders and insureds as the minimum benefits otherwise required by subsections B through I of this section;

2. The Commissioner must be satisfied that the benefits and the pattern of premiums of that plan are not such as to mislead prospective policyholders or insureds;

3. The cash surrender values and paid-up nonforfeiture benefits provided by such plan must not be less than the minimum values and benefits required for the plan computed by a method consistent with the principles of this Standard Nonforfeiture Law for Life Insurance, as determined by regulations promulgated by the Commissioner.

K. Calculation of Values: Any cash surrender value and any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment due at any time other than on the policy anniversary shall be calculated with allowance for the lapse of time and the payment of fractional premiums beyond the last preceding policy anniversary, except in the case of industrial insurance proportionate increases in value may be calculated on the basis of quarter-year payments. All values referred to in subsections D, F, G, H and I of this section may be calculated upon the assumption that any death benefit is payable at the end of the

policy year of death. The net value of any paid-up additions, other than paid-up term additions, shall be not less than the amounts used to provide such additions. Notwithstanding the provisions of subsection D of this section, additional benefits payable (1) in the event of death or dismemberment by accident or accidental means, (2) in the event of total and permanent disability, (3) as reversionary annuity or deferred reversionary annuity benefits, (4) as term insurance benefits provided by a rider or supplemental policy provision to which, if issued as a separate policy, this section would not apply, (5) as term insurance on the life of a child or on the lives of children provided in a policy on the life of a parent of the child, if such term insurance expires before the child's age is twenty-six (26) years, is uniform in amount after the child's age is one (1) year, and has not become paid up by reason of the death of a parent of the child, and (6) as other policy benefits additional to life insurance and endorsement benefits, and premiums for all such additional benefits, shall be disregarded in ascertaining cash surrender values and nonforfeiture benefits required by this section, and no such additional benefits shall be required to be included in any paid-up nonforfeiture benefits.

L. This subsection, in addition to all other applicable subsections of this section, shall apply to all policies issued on or after January 1, 1986. Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary, shall be in an amount which does not differ by more than two-tenths of one percent ($2/10$ of 1%) of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten (10) policy years, from the sum of (a) the greater of zero and the basic cash value hereinafter specified and (b) the present value of any existing paid-up additions less the amount of any indebtedness to the insurer under the policy.

The basic cash value shall be equal to the present value, on such anniversary, of the future guaranteed benefits which would have been provided for by the policy, excluding any existing paid-up additions and before deduction of any indebtedness to the insurer, if there had been no default, less the then present value of the nonforfeiture factors, as hereinafter defined, corresponding to premiums which would have fallen due on and after such anniversary. Provided, however, that the effects on the basic cash value of supplemental life insurance or annuity benefits or of family coverage, as described in subsection D or H of this section, whichever is applicable, shall be the same as are the effects specified in subsection D or H of this section, whichever is applicable on the cash surrender values defined in that subsection.

The nonforfeiture factor for each policy year shall be an amount equal to a percentage of the adjusted premium for the policy year,

as defined in subsection G or I of this section, whichever is applicable. Except as is required by the next succeeding sentence of this paragraph, such percentage:

1. Must be the same percentage for each policy year between the second policy anniversary and the later of (i) the fifth policy anniversary and (ii) the first policy anniversary at which there is available under the policy a cash surrender value in an amount, before including any paid-up additions and before deducting any indebtedness, of at least two-tenths of one percent (2/10 of 1%) of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten (10) policy years; and

2. Must be such that no percentage after the later of the two policy anniversaries specified in the preceding paragraph 1 may apply to fewer than five (5) consecutive policy years.

Provided, that no basic cash value may be less than the value which would be obtained if the adjusted premiums for the policy, as defined in subsection G or I of this section, whichever is applicable, were substituted for the nonforfeiture factors in the calculation of the basic cash value.

All adjusted premiums and present values referred to in this section shall for a particular policy be calculated on the same mortality and interest bases as are used in demonstrating the policy's compliance with the other subsections of this section. The cash surrender values referred to in this subsection shall include any endowment benefits provided for by the policy.

Any cash surrender value available other than in the event of default in a premium payment due on a policy anniversary, and the amount of any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment shall be determined in manners consistent with the manners specified for determining the analogous minimum amounts in subsections B, C, D and K and paragraph 4 of subsection I of this section. The amounts of any cash surrender values and of any paid-up nonforfeiture benefits granted in connection with additional benefits such as those listed as items (1) through (6) in subsection K of this section shall conform with the principles of this subsection.

M. 1. This section shall not apply to any of the following:

- a. reinsurance,
- b. group insurance,
- c. pure endowment,
- d. annuity or reversionary annuity contract,
- e. except as provided in paragraph 1 of subsection D of this section, term policy of uniform amount, which provides no guaranteed nonforfeiture or endowment benefits, or renewal thereof, of twenty (20) years or less expiring before age seventy-one (71) years, for

which uniform premiums are payable during the entire term of the policy,

- f. except as provided in paragraph 1 of subsection D of this section, term policy of decreasing amount which provides no guaranteed nonforfeiture or endowment benefits, on which each adjusted premium, calculated as specified in subsections G, H and I of this section, is less than the adjusted premium so calculated on a term policy of uniform amount, or renewal thereof, which provides no guaranteed nonforfeiture or endowment benefits, issued at the same age and for the same initial amount of insurance for a term defined as follows: For ages at issue fifty (50) years and under the term shall be twenty (20) years. Thereafter the term shall decrease one (1) year for each year of increase in the age at issue beyond age fifty (50) years; and
- g. policy, which provides no guaranteed nonforfeiture or endowment benefits, for which no cash surrender value, if any, or present value of any paid-up nonforfeiture benefit at the beginning of any policy year, calculated as specified in subsections D, F, G, H and I of this section, exceeds two and one-half percent (2 1/2%) of the amount of insurance at the beginning of the same policy year.

2. For purposes of determining the applicability of this act, the age at expiry for a joint term life insurance policy shall be the age at expiry of the oldest life.

Added by Laws 1957, p. 375, § 4029, operative July 1, 1957. Amended by Laws 1961, p. 271, § 2, emerg. eff. July 5, 1961; Laws 1963, c. 25, § 3; Laws 1974, c. 31, § 2, emerg. eff. April 11, 1974; Laws 1978, c. 55, § 2, emerg. eff. March 17, 1978; Laws 1982, c. 118, § 2, emerg. eff. April 6, 1982; Laws 1993, c. 248, § 4, eff. Sept. 1, 1993; Laws 2014, c. 50, § 3, eff. Nov. 1, 2014.

§36-4030. Manner of paying premiums for single premium life policies and annuity contracts.

A. Except as may be otherwise approved by the Insurance Commissioner, no single premium policy of life insurance or single premium annuity contract shall be delivered or issued for delivery in Oklahoma for a consideration other than cash, cashier's check, check, bank draft, money order, premium note or electronic payment. This act shall not apply to the transfer of securities to an insurer pursuant to the insuring of a pension or profit sharing plan qualified under the Federal Internal Revenue Code.

B. This act shall not be held to repeal or alter any law now in effect, but shall be construed as cumulative with and supplemental to other laws and acts now in effect or enacted hereafter.
Added by Laws 1970, c. 154, §§ 1, 2, emerg. eff. April 7, 1970.
Amended by Laws 2021, c. 478, § 22, emerg. eff. May 12, 2021.

§36-4030.1. Forms to establish proof of death and interest of claimant - Interest on proceeds - Payment of proceeds - Time - Exemptions.

A. Within ten (10) days after an insurer receives written notification of the death of a person covered by a policy of life insurance, the insurer shall provide to the claimant the necessary forms to be completed to establish proof of the death of the insured and, if required by the policy, the interest of the claimant. If the policy contains a provision requiring surrender of the policy prior to settlement, the insurer shall include a written statement to that effect with the forms to be completed. Forms to establish proof of death and proof of the interest of the claimant shall be approved by the Insurance Commissioner.

B. An insurer shall pay the proceeds of any benefits under a policy of life insurance not more than thirty (30) days after the insurer has received proof of death of the insured. If the proceeds are not paid within this period, the insurer shall pay interest on the proceeds, at a rate which is not less than the current rate of interest on death proceeds on deposit with the insurer, from the date of death of the insured to the date when the proceeds are paid. Should the insurer hold its deposits in a noninterest bearing account, the rate of interest to be paid shall be the same rate of interest as the average United States Treasury Bill rate of the preceding calendar year, as certified to the Insurance Commissioner by the State Treasurer on the first regular business day in January of each year, plus two (2) percentage points, which shall accrue from the thirty-first day after receipt of proof of loss until the proceeds are paid. Payment shall be deemed to have been made on the date an electronic payment is made or the date a check, draft or other valid instrument which is equivalent to payment was placed in the U.S. mails in a properly addressed, postpaid envelope; or, if not so posted, on the date of delivery of such instrument to the beneficiary.

C. Subsection B of this section shall not apply to any life insurance policy issued before October 1, 1978, which contains specific provisions to the contrary.
Added by Laws 1978, c. 162, § 3, eff. Oct. 1, 1978. Amended by Laws 1987, c. 175, § 24, eff. Nov. 1, 1987; Laws 1994, c. 294, § 7, eff. Sept. 1, 1994; Laws 2021, c. 478, § 23, emerg. eff. May 12, 2021.

§36-4030.2. Short title.

Sections 4030.2 through 4030.13 of this title shall be known and may be cited as the "Standard Nonforfeiture Law for Individual Deferred Annuities".

Added by Laws 2000, c. 353, § 16, eff. Nov. 1, 2000. Amended by Laws 2004, c. 274, § 12, eff. July 1, 2004.

§36-4030.3. Applicability of act.

This act shall not apply to any reinsurance, group annuity purchased under a retirement plan or plan of deferred compensation established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code, as now or hereafter amended, premium deposit fund, variable annuity, investment annuity, immediate annuity, any deferred annuity contract after annuity payments have commenced, or reversionary annuity, nor to any contract which shall be delivered outside this state through an agent or other representative of the company issuing the contract.

Added by Laws 2000, c. 353, § 17, eff. Nov. 1, 2000.

§36-4030.4. Conditions for approval of annuity contracts by Commissioner - Conditions for termination of contracts.

A. In the case of contracts issued on or after November 1, 2000, except as provided in Section 4030.3 of this title, no contract of annuity, except as stated in Section 4030.13 of this title, shall be delivered or issued for delivery in this state unless it contains in substance the following provisions, or corresponding provisions which in the opinion of the Insurance Commissioner are at least as favorable to the contract holder, upon cessation of payment of considerations under the contract:

1. That upon cessation of payment of considerations under a contract, the company shall grant a paid-up annuity benefit on a plan stipulated in the contract of such value as is specified in Sections 4030.6, 4030.7, 4030.9 and 4030.11 of this title;

2. If a contract provides for a lump sum settlement at maturity, or at any other time, that upon surrender of the contract at or prior to the commencement of any annuity payments, the company shall pay in lieu of a paid-up annuity benefit a cash surrender benefit of such amount as is specified in Sections 4030.6, 4030.7, 4030.9 and 4030.11 of this title. The company may reserve the right to defer the payment of the cash surrender benefit for a period not to exceed six (6) months after demand therefor with surrender of the contract after making written request and receiving the written approval of the Commissioner. The request shall address the necessity and equitability to all policyholders of the deferral;

3. A statement of the mortality table, if any, and interest rates used in calculating any minimum paid-up annuity, cash surrender or death benefits that are guaranteed under the contract, together with sufficient information to determine the amounts of the benefits; and

4. A statement that any paid-up annuity, cash surrender or death benefits that may be available under the contract are not less than the minimum benefits required by any statute of the state in which the contract is delivered and an explanation of the manner in which the benefits are altered by the existence of any additional amounts credited by the company to the contract, any indebtedness to the company on the contract or any prior withdrawals from or partial surrenders of the contract.

B. Notwithstanding the requirements of this section, a deferred annuity contract may provide that if no considerations have been received under a contract for a period of two (2) full years and the portion of the paid-up annuity benefit at maturity on the plan stipulated in the contract arising from prior considerations paid would be less than Twenty Dollars (\$20.00) monthly, the company may at its option terminate the contract by payment in cash of the then present value of the portion of the paid-up annuity benefit, calculated on the basis on the mortality table, if any, and interest rate specified in the contract for determining the paid-up annuity benefit, and by this payment shall be relieved of any further obligation under the contract.

Added by Laws 2000, c. 353, § 18, eff. Nov. 1, 2000. Amended by Laws 2004, c. 274, § 13, eff. July 1, 2004.

§36-4030.5. Minimum nonforfeiture amounts.

A. The minimum values as specified in Sections 4030.6, 4030.7, 4030.8, 4030.9 and 4030.11 of this title, of any paid-up annuity, cash surrender or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts as defined in this section.

B. 1. The minimum nonforfeiture amount at any time at or prior to the commencement of any annuity payments shall be equal to an accumulation up to such time at rates of interest as indicated in subsection C of this section of the net considerations, as hereinafter defined, paid prior to such time, decreased by the sum of:

- a. any prior withdrawals from or partial surrenders of the contract accumulated at rates of interest indicated in subsection C of this section,
- b. an annual contract charge of Fifty Dollars (\$50.00), accumulated at rates of interest indicated in subsection C of this section,

- c. any premium tax paid by the company for the contract, accumulated at rates of interest indicated in subsection C of this section, and
- d. the amount of any indebtedness to the company on the contract including interest due and accrued.

2. The net considerations for a given contract year used to define the minimum nonforfeiture amount shall be an amount equal to eighty-seven and one-half percent (87.5%) of the gross considerations credited to the contract during that contract year.

C. The interest rate used in determining minimum nonforfeiture amounts shall be an annual rate of interest determined as the lesser of three percent (3%) per annum and the following, which shall be specified in the contract if the interest rate will be reset:

1. The five-year Constant Maturity Treasury Rate reported by the Federal Reserve as of a date, or average over a period, rounded to the nearest one-twentieth of one percent (1/20 of 1%), specified in the contract no longer than fifteen (15) months prior to the contract issue date or redetermination date under paragraph 4 of this subsection;

2. Reduced by one hundred twenty-five (125) basis points;

3. If the resulting interest rate is not less than fifteen one-hundredths of one percent (.15%); and

4. The interest rate shall apply for an initial period and may be redetermined for additional periods. The redetermination date, basis and period, if any, shall be stated in the contract. The basis is the date or average over a specified period that produces the value of the five-year Constant Maturity Treasury Rate to be used at each redetermination date.

D. During the period or term that a contract provides substantive participation in an equity indexed benefit, it may increase the reduction described in paragraph 2 of subsection C of this section by up to an additional one hundred (100) basis points to reflect the value of the equity index benefit. The present value at the contract issue date, and at each redetermination date thereafter, of the additional reduction shall not exceed the market value of the benefit. The Commissioner may require a demonstration that the present value of the additional reduction does not exceed the market value of the benefit. Lacking such a demonstration that is acceptable to the Commissioner, the Commissioner may disallow or limit the additional reduction.

E. The Commissioner may adopt rules to implement the provisions of paragraph 4 of subsection C of this section and to provide for further adjustments to the calculation of minimum nonforfeiture amounts for contracts that provide substantive participation in an equity index benefit and for other contracts that the Commissioner determines are justified.

Added by Laws 2000, c. 353, § 19, eff. Nov. 1, 2000. Amended by Laws 2002, c. 307, § 30, eff. Nov. 1, 2002; Laws 2004, c. 274, § 14, eff. July 1, 2004; Laws 2021, c. 360, § 1, eff. Nov. 1, 2021.

§36-4030.6. Minimum present value at commencement of benefits.

Any paid-up annuity benefit available under a contract shall be such that its present value on the date annuity payments are to commence is at least equal to the minimum nonforfeiture amount on that date. Present value shall be computed using the mortality table, if any, and the interest rate specified in the contract for determining the minimum paid-up annuity benefits guaranteed in the contract.

Added by Laws 2000, c. 353, § 20, eff. Nov. 1, 2000.

§36-4030.7. Cash surrender benefits prior to maturity.

For contracts that provide cash surrender benefits, the cash surrender benefits available prior to maturity shall not be less than the present value as of the date of surrender of that portion of the maturity value of the paid-up annuity benefit that would be provided under the contract at maturity arising from considerations paid prior to the time of cash surrender reduced by the amount appropriate to reflect any prior withdrawals from or partial surrenders of the contract, such present value being calculated on the basis of an interest rate not more than one percent (1%) higher than the interest rate specified in the contract for accumulating the net considerations to determine maturity value, decreased by the amount of any indebtedness to the company on the contract, including interest due and accrued, and increased by any existing additional amounts credited by the company to the contract. In no event shall any cash surrender benefit be less than the minimum nonforfeiture amount at that time. The death benefit under such contracts shall be at least equal to the cash surrender benefit.

Added by Laws 2000, c. 353, § 21, eff. Nov. 1, 2000.

§36-4030.8. Present value of paid-up annuity benefit available as nonforfeiture option.

For contracts that do not provide cash surrender benefits, the present value of any paid-up annuity benefit available as a nonforfeiture option at any time prior to maturity shall not be less than the present value of that portion of the maturity value of the paid-up annuity benefit provided under the contract arising from considerations paid prior to the time the contract is surrendered in exchange for, or changed to, a deferred paid-up annuity, such present value being calculated for the period prior to the maturity date on the basis of the interest rate specified in the contract for accumulating the net considerations to determine maturity value, and increased by any existing additional amounts credited by the company

to the contract. For contracts that do not provide any death benefits prior to the commencement of any annuity payments, present values shall be calculated on the basis of such interest rate and the mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit. However, in no event shall the present value of a paid-up annuity benefit be less than the minimum nonforfeiture amount at that time.
Added by Laws 2000, c. 353, § 22, eff. Nov. 1, 2000.

§36-4030.9. Maturity dates.

For the purpose of determining the benefits calculated under Sections 4030.7 and 4030.8 of this title for annuity contracts issued on or after November 1, 2013, the maturity date shall be deemed to be the latest date for which election shall be permitted by the contract, but shall not be deemed to be later than the anniversary of the contract next following the annuitant's seventieth birthday or the tenth anniversary of the contract, whichever is later. However, if surrender charge scales are measured from the date of each premium payment, the maturity date shall be deemed to be the latest date for which election shall be permitted by the contract, but shall not be deemed to be later than the anniversary of the contract next following the annuitant's seventieth birthday or the tenth anniversary of the payment, whichever is later.

Added by Laws 2000, c. 353, § 23, eff. Nov. 1, 2000. Amended by Laws 2004, c. 274, § 15, eff. July 1, 2004; Laws 2013, c. 269, § 10, eff. Nov. 1, 2013; Laws 2014, c. 275, § 17, eff. Nov. 1, 2014.

§36-4030.10. Statement required when certain benefits not provided.

A contract that does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount prior to the commencement of any annuity payments shall include a statement in a prominent place in the contract that such benefits are not provided.

Added by Laws 2000, c. 353, § 24, eff. Nov. 1, 2000.

§36-4030.11. Calculation of certain benefits under contracts with fixed scheduled considerations.

Any paid-up annuity, cash surrender or death benefits available at any time, other than on the contract anniversary under any contract with fixed scheduled considerations, shall be calculated with allowance for the lapse of time and the payment of any scheduled considerations beyond the beginning of the contract year in which cessation of payment of considerations under the contract occurs.

Added by Laws 2000, c. 353, § 25, eff. Nov. 1, 2000.

§36-4030.12. Minimum nonforfeiture requirements for contracts providing both annuity and life insurance benefits.

For a contract which provides, within the same contract by rider or supplemental contract provision, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits shall be equal to the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion computed as if each portion were a separate contract. Notwithstanding the provisions of Sections 4030.6, 4030.7, 4030.8, 4030.9, and 4030.11 of this title, additional benefits payable in the event of total and permanent disability, as reversionary annuity or deferred reversionary annuity benefits, or as other policy benefits additional to life insurance, endowment and annuity benefits, and considerations for all such additional benefits, shall be disregarded in ascertaining the minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits that may be required by the Standard Nonforfeiture Law for Individual Deferred Annuities. The inclusion of such benefits shall not be required in any paid-up benefits, unless the additional benefits separately would require minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits. Added by Laws 2000, c. 353, § 26, eff. Nov. 1, 2000. Amended by Laws 2004, c. 274, § 16, eff. July 1, 2004.

§36-4030.13. Operative date of act.

Beginning November 1, 2004, a company may elect to apply its provisions to annuity contracts filed and approved before November 1, 2004, on a form-by-contract-form basis. Annuity contracts filed for approval and to be issued on or before November 1, 2004, must comply with the provisions of the Standard Nonforfeiture Law for Individual Deferred Annuities. In all other instances, the Standard Nonforfeiture Law for Individual Deferred Annuities shall become operative with respect to annuity contracts issued by the company after November 1, 2006. Added by Laws 2000, c. 353, § 27, eff. Nov. 1, 2000. Amended by Laws 2004, c. 274, § 17, eff. July 1, 2004.

§36-4031. Short title.

Sections 1 through 8 of this act shall be known and may be cited as the "Life Insurance and Annuity Policyholders Protection Act". Added by Laws 1983, c. 80, § 1, eff. Nov. 1, 1983.

§36-4032. Application of act.

A. The provisions of the Life Insurance and Annuity Policyholders Protection Act shall apply to life insurance and

annuity policies which cover residents of this state and which are solicited and issued by insurance corporations, fraternal benefit societies, associations, or other institutions which issue life insurance or annuity policies.

B. The provisions of the Life Insurance and Annuity Policyholders Protection Act shall not apply to:

1. credit life insurance policies; or
2. group life insurance policies or group annuity policies; or
3. contracts issued in connection with employee benefits or welfare plans as defined by the Federal Employee Retirement Income Security Act of 1974 (ERISA), Public Law 93-406, as amended; or
4. the exercise by an insured of an existing contractual right with the same insurer for the purchase of additional insurance under a guaranteed insurability provision or conversion option or any other contractual policy change privilege; or
5. short-term nonrenewable life insurance policies written to cover periods of thirty-one (31) days or less; or
6. an existing nonconvertible term life insurance policy which will expire in five (5) years or less and which cannot be renewed; or
7. a proposed life insurance policy that is to replace life insurance under a binding or conditional receipt issued by the same company issuing the policy which is to be replaced.

Added by Laws 1983, c. 80, § 2, eff. Nov. 1, 1983.

§36-4033. Definitions.

As used in the Life Insurance and Annuity Policyholders Protection Act:

1. "Replacement" means any transaction in which a new life insurance policy or a new annuity policy is to be purchased, and it is known or should be known by the proposing agent, or by the proposing insurer if there is no agent, that an existing individual life insurance policy or an annuity policy has been, or is to be lapsed, surrendered, converted, become extended insurance, or that the cash loan value, or any portion thereof, is used or contemplated for use in the future with the purchase of a new insurance policy or annuity policy.

2. "Notice" means a document completed by the applicant and the agent or insurer prior to completing a new application for a life insurance policy or annuity policy when an agent is involved or delivered with the policy when no agent is involved, which provides information regarding replacement transactions. The document shall be in substantially the same format for all insurers.

3. "Statement" means a document to be signed by the agent or the applicant or both the agent and the applicant, which notifies the replaced insurer of the replacement.

Added by Laws 1983, c. 80, § 3, eff. Nov. 1, 1983.

§36-4034. Application for insurance - Statement required - Replacement policy.

A. Every insurer operating in this state shall inform its agents of the provisions of this section.

B. Every agent shall secure with or as a part of each application for insurance a statement as to whether the new insurance policy or annuity policy will replace an existing insurance policy or annuity policy on the same life.

C. The insurer shall review each statement prior to commencing any underwriting. The review shall occur not later than five (5) days after receipt of the application by the insurer to determine if the policy is a replacement policy. If the insurer determines that the policy is a replacement policy and if the agent has not secured and forwarded the documents required by the provisions of subsection D of this section to the insurer, the insurer shall cause the agent to secure and forward said documents.

D. If a policy is a replacement policy, the agent shall secure and forward to the insurer with each application the following:

1. A completed notice as provided for in Section 5 of the Life Insurance and Annuity Policyholders Protection Act; and

2. A signed statement as provided for in Section 6 of the Life Insurance and Annuity Policyholders Protection Act. If the applicant declines to sign the statement, the agent shall furnish to the insurer a written statement to that effect, signed by the agent which shall be in addition to the signed agent's certification; and

3. Copies of the sales material prepared by the agent. If the material is not substantially correct as determined by the insurer, the insurer shall delay processing the application until corrected information has been presented to and acknowledged by the applicant.

E. If the statement provided for in Section 6 of the Life Insurance and Annuity Policyholders Protection Act is not received by the insurer with the application or if the statement is received unsigned, it shall be presumed by the insurer that the applicant desires that the transaction be confidential and the replacing insurer shall not notify the replaced insurer. If the applicant signs the statement indicating that the replaced insurer be notified, then the replacing insurer shall send a written notification of the replacement to the home office of each replaced insurer within five (5) days of receipt of the application. Notification shall include the name of the applicant, the name of the insured, the number of the policy being replaced, the generic name and the face amount of the replacing policy, and the legal name of the insurers.

F. The replacing insurer shall maintain copies of the notice, statement, and notifications to the replaced insurers for at least

three (3) years. Said copies shall be indexed so as to be readily available for review by the Insurance Commissioner or his designee.

G. The insurer shall guarantee the policyholder at least a twenty-day right to return the policy after delivery for a full refund of premium. The insurer shall provide prominent written notice informing the policyholder of this right. Said notice shall be attached to, or as part of, the first page of the policy.

H. If only an insurer is involved with the replacement of a life insurance policy or an annuity policy of residents of this state, the requirements provided for in this section, where applicable, shall be followed.

Added by Laws 1983, c. 80, § 4, eff. Nov. 1, 1983. Added by Laws 1983, c. 80, § 4, eff. Nov. 1, 1983.

§36-4035. Notice to applicants regarding replacement of life insurance or annuity.

The notice referred to in the Life Insurance and Annuity Policyholders Protection Act shall be delivered to the applicant for a replacement life insurance policy or a replacement annuity policy. The legal name and address of the replacing insurer may be printed on the notice. Said notice shall be in substance as follows:

NOTICE TO APPLICANTS REGARDING REPLACEMENT OF LIFE INSURANCE OR AN ANNUITY. THIS NOTICE IS FOR YOUR BENEFIT AND IS REQUIRED BY LAW.

1. If you are urged to purchase life insurance and to surrender, lapse, or in any other way change the status of existing life insurance, the agent is required to give you this notice.

2. It may not be advantageous to drop or change existing life insurance in favor of new life insurance, whether issued by the same or a different insurance company. Some of the disadvantages are:

a. The amount of the annual premium under an existing policy may be lower than that under a new policy having the same or similar benefits.

b. Generally, the initial costs of life insurance policies are charged against the cash value increases in the earlier policy years, the replacement of an old policy could result in the policyholder sustaining the burden of these costs twice.

c. The incontestable and suicide clauses begin anew in a new policy. This could result in a claim under a new policy being denied by the company which would have been paid under the old policy.

d. Existing policies may have more favorable provisions than new policies in such areas as settlement options and disability benefits.

e. An existing policy may have a reserve value in addition to any cash value which may be of some benefit to the insured.

f. The insurance company carrying your current insurance policy can often make a desired change on terms which would be more favorable than if existing insurance is replaced with new insurance.

3. It may not be advantageous to change an existing policy to reduced paid-up or extended term insurance or to borrow against its loan value beyond your expected ability or intention to repay in order to obtain funds for premiums on a new policy.

4. There may be a situation in which a replacement policy is advantageous. You may want to receive the comments of the present insurance company before deciding this important financial matter. I hereby acknowledge that I received the above "Notice to Applicants Regarding Replacement of Life Insurance or an Annuity" before I signed the application for the proposed new insurance.

Date Signature of Applicant
Subparagraph c of paragraph 2 of this section shall be in 12-point type.

Added by Laws 1983, c. 80, § 5, eff. Nov. 1, 1983.

§36-4036. Statement by applicant regarding notification of replacement to replaced insurer.

The statement referred to in the Life Insurance and Annuity Policyholders Protection Act shall be delivered to the applicant for a replacement life insurance policy or a replacement annuity policy along with the notice provided for in Section 5 of the Life Insurance and Annuity Policyholders Protection Act. The legal name and address of the replacing insurer may be printed on the statement. Said statement shall be in substance as follows:

STATEMENT BY APPLICANT REGARDING NOTIFICATION
OF REPLACEMENT TO THE REPLACED INSURER

I have read the "NOTICE TO APPLICANTS REGARDING REPLACEMENT OF LIFE INSURANCE OR AN ANNUITY" which was furnished to me by the agent taking the application for this policy.

(Applicant: Please sign ONE of the following statements.)

1. Please notify my present insurer(s) regarding this transaction.

Date Signature of Applicant
2. Please do not notify my present insurer(s) regarding this transaction.

Date Signature of Applicant

The signature of the applicant shall be that of the insured unless someone other than the insured is the owner of the policy. If

someone other than the insured is the owner of the policy, the owner must sign. If the insured is under eighteen (18) years of age, the parent is deemed to be the owner of the policy.

Certification by the agent:

I hereby certify that nothing was said or done during the sales presentation to influence the decision of the applicant regarding this statement.

Date

Signature of Agent

Insurance Agency or Agent
License Number

Added by Laws 1983, c. 80, § 6, eff. Nov. 1, 1983.

§36-4037. Definitions to be delivered to applicant for replacement life insurance policy or annuity.

The following definitions shall be on a form prepared by the insurer and shall be delivered to the applicant for a replacement life insurance policy or a replacement annuity policy along with the notice and statement provided for in Sections 4035 and 4036 of the Life Insurance and Annuity Policyholders Protection Act, Sections 4031 et seq. of this title:

DEFINITIONS

Premiums: Premiums are the payments you make on the life insurance or annuity contract. They are unlike deposits in a savings or investment program because if you drop the policy you might get back less than you paid in.

Cash Surrender Value: This is the amount of money you can get if you surrender your life insurance policy or annuity. If there is a policy loan, the cash surrender value is the difference between the cash value printed in the policy and the loan value. Not all policies have cash surrender values.

Lapse: A life insurance policy may lapse when you do not pay the premiums within the grace period. If your policy had a cash surrender value, the insurer might change your policy to as much extended term insurance or paid-up insurance as the cash surrender value will buy. Sometimes the policy lets the insurer borrow from the cash surrender value to pay the premiums.

Surrender: You surrender a life insurance policy when you either let it lapse or tell the company you want to drop it. If a policy has a cash surrender value, you can receive such value in cash if you return the policy to the company with a written request.

Place on Extended Term: This means you use your cash surrender value to change your insurance to term insurance with the same insurer. In this case, the net death benefit will be the same

as before but you will only be covered for a specified period of time.

Borrow Policy Loan Values: If your life insurance policy has a cash surrender value, you can usually borrow all or part of said amount from the insurer. Interest will be charged according to the terms of the policy, and if the loan and unpaid interest ever exceeds the cash surrender value the policy will be terminated. If you die, the amount of the loan and any unpaid interest due will be subtracted from the death benefits.

Evidence of Insurability: This means proof that you are an acceptable risk. You have to meet the standards of the insurer regarding age, health, occupation, and such other standards as the insurer feels necessary to be eligible for coverage.

Incontestable Clause: This says that after one (1) or two (2) years, according to the provisions of the contract, the insurer shall not resist a claim because you made a false or incomplete statement when you applied for the policy. During the first two (2) years if there are false or incomplete answers on the application and the insurer discovers them, the insurer can deny a claim as if the policy has never existed.

Suicide Clause: This says that if you commit suicide after being insured for less than two (2) years, your beneficiaries will receive only a refund of the premiums that were paid. The definitions of incontestable clause and suicide clause shall be in 12-point type.

Added by Laws 1983, c. 80, § 7, eff. Nov. 1, 1983. Amended by Laws 1984, c. 149, § 15, eff. Nov. 1, 1984.

§36-4038. Violations - Penalties.

Violation of any provision of the Life Insurance and Annuity Policyholders Protection Act may result in censure, suspension, or revocation of the insurance license or certificate or a fine of no more than One Thousand Dollars (\$1,000.00) per incident, or both. Added by Laws 1983, c. 80, § 8, eff. Nov. 1, 1983.

§36-4041. Repealed by Laws 2008, c. 183, § 19, eff. Nov. 1, 2008.

§36-4042. Repealed by Laws 2008, c. 183, § 19, eff. Nov. 1, 2008.

§36-4043. Repealed by Laws 2008, c. 183, § 19, eff. Nov. 1, 2008.

§36-4044. Repealed by Laws 2008, c. 183, § 19, eff. Nov. 1, 2008.

§36-4045. Repealed by Laws 2008, c. 183, § 19, eff. Nov. 1, 2008.

§36-4046. Repealed by Laws 2008, c. 183, § 19, eff. Nov. 1, 2008.

§36-4046.1. Repealed by Laws 2008, c. 183, § 19, eff. Nov. 1, 2008.

§36-4047. Repealed by Laws 2008, c. 183, § 19, eff. Nov. 1, 2008.

§36-4048. Repealed by Laws 2008, c. 183, § 19, eff. Nov. 1, 2008.

§36-4048.1. Repealed by Laws 2008, c. 183, § 19, eff. Nov. 1, 2008.

§36-4049. Repealed by Laws 2008, c. 183, § 19, eff. Nov. 1, 2008.

§36-4050. Repealed by Laws 2008, c. 183, § 19, eff. Nov. 1, 2008.

§36-4051. Repealed by Laws 2008, c. 183, § 19, eff. Nov. 1, 2008.

§36-4051.1. Repealed by Laws 2008, c. 183, § 19, eff. Nov. 1, 2008.

§36-4051.2. Repealed by Laws 2008, c. 183, § 19, eff. Nov. 1, 2008.

§36-4052. Repealed by Laws 2008, c. 183, § 19, eff. Nov. 1, 2008.

§36-4055.1. Short title.

Sections 1 through 17 of this act shall be known and may be cited as the "Viatical Settlements Act of 2008".

Added by Laws 2008, c. 183, § 1, eff. Nov. 1, 2008.

§36-4055.2. Definitions.

As used in the Viatical Settlements Act of 2008:

1. "Advertising" means any written, electronic or printed communication or any communication by means of recorded telephone messages or transmitted on radio, television, the Internet or similar communications media, including film strips, motion pictures and videos, published, disseminated, circulated or placed directly before the public, in this state, for the purpose of creating an interest in or inducing a person to sell, assign, devise, bequest or transfer the death benefit or ownership of a life insurance policy pursuant to a viatical settlement contract;

2. "Business of viatical settlements" means an activity involved in, but not limited to, the offering, soliciting, negotiating, procuring, effectuating, purchasing, investing, financing, monitoring, tracking, underwriting, selling, transferring, assigning, pledging, hypothecating or in any other manner acquiring an interest in a life insurance policy by means of a viatical settlement contract;

3. "Chronically ill" means:

a. being unable to perform at least two activities of daily living, including, but not limited to, eating,

toileting, transferring, bathing, dressing or continence,

- b. requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment, or
- c. having a level of disability similar to that described in subparagraph a of this paragraph as determined by the Secretary of Human Services;

4. "Commissioner" means the Insurance Commissioner of the State of Oklahoma;

5. "Financing entity" means an underwriter, placement agent, lender, purchaser of securities, purchaser of a policy or certificate from a viatical settlement provider, credit enhancer, or any entity that has a direct ownership in a policy or certificate that is the subject of a viatical settlement contract, but:

- a. whose principal activity related to the transaction is providing funds to effect the viatical settlement or purchase of one or more viaticated policies, and
- b. who has an agreement in writing with one or more licensed viatical settlement providers to finance the acquisition of viatical settlement contracts.

Financing entity does not include a nonaccredited investor or a viatical settlement purchaser;

6. "Financing transaction" means a transaction in which a licensed provider obtains financing from a financing entity, including, without limitation, any secured or unsecured financing, any securitization transaction, or any securities offering which either is registered or exempt from registration under federal and state securities law;

7. "Fraudulent viatical settlement act" includes:

- a. acts or omissions committed by any person who, knowingly and with intent to defraud, for the purpose of depriving another of property or for pecuniary gain, commits, or permits its employees or its agents to engage in acts including:
 - (1) presenting, causing to be presented or preparing with knowledge or belief that it will be presented to or by a viatical settlement provider, viatical settlement broker, viatical settlement purchaser, financing entity, insurer, insurance producer or any other person, false material information, or concealing material information, as part of, in support of or concerning a fact material to one or more of the following:

- (a) an application for the issuance of a viatical settlement contract or insurance policy,
- (b) the underwriting of a viatical settlement contract or insurance policy,
- (c) a claim for payment or benefit pursuant to a viatical settlement contract or insurance policy,
- (d) premiums paid on an insurance policy,
- (e) payments and changes in ownership or beneficiary made in accordance with the terms of a viatical settlement contract or insurance policy,
- (f) the reinstatement or conversion of an insurance policy,
- (g) in the solicitation, offer, effectuation or sale of a viatical settlement contract or insurance policy,
- (h) the issuance of written evidence of viatical settlement contract or insurance, or
- (i) a financing transaction,
- (2) intentionally failing to disclose to the insurer when requested by the insurer that the prospective insured has knowingly undergone a life expectancy evaluation by any person or entity other than the insured or its authorized representatives in connection with the issuance of the policy,
- (3) in the solicitation, application or issuance of a life insurance policy, employing any device, scheme or artifice in violation of Section 3604 of Title 36 of the Oklahoma Statutes, and
- (4) employing any plan, financial structure, device, scheme, or artifice to defraud related to viaticated policies,
- b. in the furtherance of a fraud or to prevent the detection of a fraud any person commits or permits its employees or its agents to:
 - (1) remove, conceal, alter, destroy or sequester from the Commissioner the assets or records of a licensee or other person engaged in the business of viatical settlements,
 - (2) misrepresent or conceal the financial condition of a licensee, financing entity, insurer or other person,
 - (3) transact the business of viatical settlements in violation of laws requiring a license,

certificate of authority or other legal authority for the transaction of the business of viatical settlements, or

- (4) file with the Commissioner or the equivalent chief insurance regulatory official of another jurisdiction a document containing false information or otherwise conceals information about a material fact from the Commissioner,
- c. embezzlement, theft, misappropriation or conversion of monies, funds, premiums, credits or other property of a viatical settlement provider, insurer, insured, viator, insurance policyowner or any other person engaged in the business of viatical settlements or insurance,
- d. recklessly entering into, negotiating, brokering, otherwise dealing in a viatical settlement contract, the subject of which is a life insurance policy that was obtained by presenting false information concerning any fact material to the policy or by concealing, for the purpose of misleading another, information concerning any fact material to the policy, where the person or the persons intended to defraud the policy's issuer, the viatical settlement provider or the viator. Recklessly means engaging in the conduct in conscious and clearly unjustifiable disregard of a substantial likelihood of the existence of the relevant facts or risks, such disregard involving a gross deviation from acceptable standards of conduct,
- e. stranger-originated life insurance,
- f. facilitating the change of state of ownership of a policy or certificate or the state of residency of a viator to a state or jurisdiction that does not have a law similar to this act for the express purposes of evading or avoiding the provisions of the Viatical Settlements Act of 2008, or
- g. attempting to commit, assisting, aiding or abetting in the commission of, or conspiracy to commit the acts or omissions specified in this paragraph;

8. "Life insurance producer" means any person licensed in this state as a resident or nonresident insurance producer who has received qualification or authority for life insurance coverage or a life line of coverage pursuant to the Oklahoma Producer Licensing Act;

9. "Person" means a natural person or a legal entity, including, without limitation, an individual, partnership, limited liability company, association, trust, or corporation;

10. "Policy" means an individual or group policy, group certificate, contract or arrangement of life insurance owned by a resident of this state, regardless of whether delivered or issued for delivery in this state;

11. "Related provider trust" means a titling trust or other trust established by a licensed viatical settlement provider or a financing entity for the sole purpose of holding the ownership or beneficial interest in purchased policies in connection with a financing transaction. The trust shall have a written agreement with the licensed viatical settlement provider under which the licensed viatical settlement provider is responsible for ensuring compliance with all statutory and regulatory requirements and under which the trust agrees to make all records and files related to viatical settlement transactions available to the Commissioner as if those records and files were maintained directly by the licensed viatical settlement provider;

12. "Special purpose entity" means a corporation, partnership, trust, limited liability company or other similar entity formed solely to provide either directly or indirectly access to institutional capital markets:

- a. for a financing entity or licensed viatical settlement provider, or
- b. (1) in connection with a transaction in which the securities in the special purposes entity are acquired by the viator or by "qualified institutional buyers" as defined in Rule 144 promulgated under the Federal Securities Act of 1933, as amended, or
(2) the securities pay a fixed rate of return commensurate with established asset-backed institutional capital markets;

13. "Stranger-originated life insurance" means a practice or plan to initiate a life insurance policy for the benefit of a third-party investor who, at the time of policy origination, has no insurable interest in the insured. Stranger-originated life insurance practices include, but are not limited to, cases in which life insurance is purchased with resources or guarantees from or through a person or entity who, at the time of policy inception, could not lawfully initiate the policy, and where, at the time of policy inception, there is an arrangement or agreement, whether verbal or written, to directly or indirectly transfer the ownership of the policy or the policy benefits to a third party. Trusts that are created to give the appearance of insurable interest and are used to initiate policies for investors violate Section 3604 of Title 36 of the Oklahoma Statutes and the prohibition against wagering on human life. Stranger-originated life insurance

arrangements do not include the practices provided in subparagraph b of paragraph 15 of this section;

14. "Terminally ill" means having an illness or sickness that can reasonably be expected to result in death in twenty-four (24) months or less;

15. "Viatical settlement broker" means a person, including a life insurance producer as provided for in Section 3 of Enrolled Senate Bill No. 1980 of the 2nd Session of the 51st Oklahoma Legislature, who working exclusively on behalf of a viator and for a fee, commission or other valuable consideration, offers or attempts to negotiate viatical settlement contracts between a viator and one or more viatical settlement providers or one or more viatical settlement brokers. Notwithstanding the manner in which the viatical settlement broker is compensated, a viatical settlement broker is deemed to represent only the viator, and not the insurer or the viatical settlement provider, and owes a fiduciary duty to the viator to act according to the viator's instructions and in the best interest of the viator. The term does not include an attorney, certified public accountant or a financial planner accredited by a nationally recognized accreditation agency, who is retained to represent the viator and whose compensation is not paid directly or indirectly by the viatical settlement provider or purchaser;

16. "Viatical settlement contract" means a written agreement between a viator and a viatical settlement provider or any affiliate of the viatical settlement provider establishing the terms under which compensation or anything of value is or will be paid, which compensation or value is less than the expected death benefits of the policy, in return for the viator's present or future assignment, transfer, sale, devise or bequest of the death benefit or ownership of any portion of the insurance policy or certificate of insurance. Viatical settlement contract also means the transfer for compensation or value of ownership or beneficial interest in a trust or other entity that owns such policy if the trust or other entity was formed or availed of for the principal purpose of acquiring one or more life insurance contracts, which life insurance contracts insure the life of a person residing in this state.

- a. Viatical settlement contract includes a premium finance loan made for a life insurance policy by a lender to viator on, before or less than two (2) years after the date of issuance of the policy where:
 - (1) the viator or the insured receives on the date of the premium finance loan a guarantee of a future viatical settlement value of the policy, or
 - (2) the viator or the insured agrees on the date of the premium finance loan to sell the policy or any portion of its death benefit on any date following the issuance of the policy.

- b. Viatical settlement contract does not include:
- (1) a policy loan or accelerated death benefit made by the insurer pursuant to the policy's terms,
 - (2) loan proceeds that are used solely to pay:
 - (a) premiums for the policy, and
 - (b) the costs of the loan, including, without limitation, interest, arrangement fees, utilization fees and similar fees, closing costs, legal fees and expenses, trustee fees and expenses, and third-party collateral provider fees and expenses, including fees payable to letter of credit issuers,
 - (3) a loan made by a bank or other licensed financial institution in which the lender takes an interest in a life insurance policy solely to secure repayment of a loan or, if there is a default on the loan and the policy is transferred, the transfer of such a policy by the lender, provided that neither the default on the loan nor the transfer of the policy in connection with the default is pursuant to an agreement or understanding with any other person for the purpose of evading regulation under this act,
 - (4) a loan made by a lender that does not violate Sections 4-101 through 4-304 of Title 14A of the Oklahoma Statutes, provided that the premium finance loan is not described in this subparagraph,
 - (5) an agreement where all the parties:
 - (a) are closely related to the insured by blood or law, or
 - (b) have a lawful substantial economic interest in the continued life, health and bodily safety of the person insured, or are trusts established primarily for the benefit of such parties,
 - (6) any designation, consent or agreement by an insured who is an employee of an employer in connection with the purchase by the employer, or trust established by the employer, of life insurance on the life of the employee,
 - (7) a bona fide business succession planning arrangement:
 - (a) between one or more shareholders in a corporation or between a corporation and one or more of its shareholders or one or more trusts established by its shareholders,

- (b) between one or more partners in a partnership or between a partnership and one or more of its partners or one or more trusts established by its partners, or
- (c) between one or more members in a limited liability company or between a limited liability company and one or more of its members or one or more trusts established by its members,
- (8) an agreement entered into by a service recipient, or a trust established by the service recipient, and a service provider, or a trust established by the service provider, who performs significant services for the service recipient's trade or business, or
- (9) any other contract, transaction or arrangement exempted from the definition of viatical settlement contract by the Commissioner based on a determination that the contract, transaction or arrangement is not of the type intended to be regulated by the Viatical Settlements Act of 2008;

17. "Viatical settlement provider" means a person, other than a viator, that enters into or effectuates a viatical settlement contract with a viator resident in this state. Viatical settlement provider does not include:

- a. a bank, savings bank, savings and loan association, credit union or other licensed lending institution that takes an assignment of a life insurance policy solely as collateral for a loan,
- b. a premium finance company making premium finance loans and exempted by the Commissioner from the licensing requirement under the premium finance laws that takes an assignment of a life insurance policy solely as collateral for a loan,
- c. the issuer of the life insurance policy,
- d. an authorized or eligible insurer that provides stop loss coverage or financial guaranty insurance to a viatical settlement provider, purchaser, financing entity, special purpose entity or related provider trust,
- e. a natural person who enters into or effectuates no more than one agreement in a calendar year for the transfer of life insurance policies for any value less than the expected death benefit,
- f. a financing entity,
- g. a special purpose entity,

- h. a related provider trust,
- i. a viatical settlement purchaser, or
- j. any other person that the Commissioner determines is not the type of person intended to be covered by the definition of viatical settlement provider;

18. "Viatical settlement purchaser" means a person who provides a sum of money as consideration for a life insurance policy or an interest in the death benefits of a life insurance policy, or a person who owns or acquires or is entitled to a beneficial interest in a trust that owns a viatical settlement contract or is the beneficiary of a life insurance policy that has been or will be the subject of a viatical settlement contract, for the purpose of deriving an economic benefit. Viatical settlement purchaser does not include:

- a. a licensee under the Viatical Settlements Act of 2008,
- b. an accredited investor or qualified institutional buyer as defined, respectively, in Rule 501(a) or Rule 144A promulgated under the Federal Securities Act of 1933, as amended,
- c. a financing entity,
- d. a special purpose entity, or
- e. a related provider trust;

19. "Viaticated policy" means a life insurance policy or certificate that has been acquired by a viatical settlement provider pursuant to a viatical settlement contract; and

20. "Viator" means the owner of a life insurance policy or a certificate holder under a group policy who resides in this state and enters or seeks to enter into a viatical settlement contract. For the purposes of the Viatical Settlements Act of 2008, a viator shall not be limited to an owner of a life insurance policy or a certificate holder under a group policy insuring the life of an individual with a terminal or chronic illness or condition except where specifically addressed. If there is more than one viator on a single policy and the viators are residents of different states, the transaction shall be governed by the law of the state in which the viator having the largest percentage ownership resides or, if the viators hold equal ownership, the state of residence of one viator agreed upon in writing by all the viators. Viator does not include:

- a. a licensee under the Viatical Settlements Act of 2008, including a life insurance producer acting as a viatical settlement broker pursuant to the Viatical Settlements Act of 2008,
- b. qualified institutional buyer as defined, respectively, in Rule 144A promulgated under the Federal Securities Act of 1933, as amended,
- c. a financing entity,
- d. a special purpose entity, or

e. a related provider trust.

Added by Laws 2008, c. 183, § 2, eff. Nov. 1, 2008. Amended by Laws 2008, c. 344, § 2, eff. Nov. 1, 2008.

§36-4055.3. License required - Application procedures - Renewal - Authority granted by license - Nonresidents - New or revised information - Training.

A. 1. A person shall not operate as a viatical settlement provider or viatical settlement broker without first obtaining a license from the Insurance Commissioner of the state of residence of the viator.

2. a. A life insurance producer who has been duly licensed as a resident insurance producer with a life line of authority in this state or his or her home state for at least one (1) year and is licensed as a nonresident producer in this state shall be deemed to meet the licensing requirements of this section and shall be permitted to operate as a viatical settlement broker.
- b. Not later than thirty (30) days from the first day of operating as a viatical settlement broker, the life insurance producer shall notify the Commissioner that he or she is acting as a viatical settlement broker on a form prescribed by the Commissioner, and shall pay any applicable fee to be determined by the Commissioner. Notification shall include an acknowledgement by the life insurance producer that he or she will operate as a viatical settlement broker in accordance with the Viatical Settlements Act of 2008.
- c. The insurer that issued the policy being viaticated shall not be responsible for any act or omission of a viatical settlement broker or viatical settlement provider arising out of or in connection with the viatical settlement transaction, unless the insurer receives compensation for the placement of a viatical settlement contract from the viatical settlement provider or viatical settlement broker in connection with the viatical settlement contract.

3. A person licensed as an attorney, certified public accountant or financial planner accredited by a nationally recognized accreditation agency, who is retained to represent the viator, whose compensation is not paid directly or indirectly by the viatical settlement provider, may negotiate viatical settlement contracts on behalf of the viator without having to obtain a license as a viatical settlement broker.

B. Application for a viatical settlement provider or a viatical settlement broker license shall be made to the Commissioner by the

applicant on a form prescribed by the Commissioner. The application shall be accompanied by a fee of Five Hundred Dollars (\$500.00).

C. Licenses may be renewed from year to year on the anniversary date upon payment of the annual renewal fees of Five Hundred Dollars (\$500.00). Failure to pay the fees by the renewal date results in expiration of the license.

D. The applicant shall provide information on forms required by the Commissioner. The Commissioner shall have authority, at any time, to require the applicant to fully disclose the identity of all stockholders, partners, officers, members and employees, and the Commissioner may, in the exercise of the Commissioner's discretion, refuse to issue a license in the name of a legal entity if not satisfied that any officer, employee, stockholder, partner or member thereof who may materially influence the applicant's conduct meets the standards of the Viatical Settlements Act of 2008.

E. A license issued to a legal entity authorizes all partners, officers, members and designated employees to act as viatical settlement providers, viatical settlement brokers as applicable, under the license, and all those persons shall be named in the application and any supplements to the application.

F. Upon the filing of an application and the payment of the license fee, the Commissioner shall make an investigation of each applicant and issue a license if the Commissioner finds that the applicant:

1. If a viatical settlement provider, has provided a detailed plan of operation;

2. Is competent and trustworthy and intends to act in good faith in the capacity involved by the license applied for;

3. Has a good business reputation and has had experience, training or education so as to be qualified in the business for which the license is applied for;

4. a. If a viatical settlement provider, has demonstrated evidence of financial responsibility in a format prescribed by the Commissioner, through a surety bond executed and issued by an insurer authorized to issue surety bonds in this state, a policy of errors and omissions insurance, or a deposit of cash, certificates of deposit or securities or any combination thereof in the amount of Fifty Thousand Dollars (\$50,000.00), or

- b. If a viatical settlement broker, has demonstrated evidence of financial responsibility in a format prescribed by the Commissioner, through a surety bond executed and issued by an insurer authorized to issue surety bonds in this state, a policy of errors and omissions insurance, or a deposit of cash, certificates of deposit or securities or any

combination thereof in the amount of Fifty Thousand Dollars (\$50,000.00), or

- c. The Commissioner may ask for evidence of financial responsibility at any time the Commissioner deems necessary;

5. If a legal entity, provides a certificate of good standing from the state of its domicile; and

6. If a viatical settlement provider or viatical settlement broker, has provided an antifraud plan that meets the requirements of subsection G of Section 13 of Enrolled Senate Bill No. 1980 of the 2nd Session of the 51st Oklahoma Legislature.

- G. The Commissioner shall not issue a license to a nonresident applicant, unless a written designation of an agent for service of process is filed and maintained with the Commissioner, or the applicant has filed with the Commissioner the applicant's written irrevocable consent that any action against the applicant may be commenced against the applicant by service of process on the Commissioner.

- H. A viatical settlement provider, viatical settlement broker or viatical settlement investment agent shall provide to the Commissioner new or revised information about officers, ten percent (10%) or more stockholders, partners, directors, members or designated employees within thirty (30) days of the change.

- I. An individual licensed as a viatical settlement broker shall complete on a biennial basis eight (8) hours of training related to viatical settlements and viatical settlement transactions, as required by the Commissioner; provided, however, that a life insurance producer who is operating as a viatical settlement broker pursuant to paragraph 2 of subsection A of this section shall not be subject to the requirements of this subsection. Any person failing to meet the requirements of this subsection shall be subject to the penalties imposed by the Commissioner.

Added by Laws 2008, c. 183, § 3, eff. Nov. 1, 2008. Amended by Laws 2008, c. 344, § 3, eff. Nov. 1, 2008; Laws 2019, c. 294, § 7, eff. Nov. 1, 2019.

§36-4055.4. Denial, suspension, revocation or nonrenewal of license - Hearing.

- A. The Insurance Commissioner may refuse to issue, suspend, revoke or refuse to renew the license of a viatical settlement provider or viatical settlement broker if the Commissioner finds that:

1. There was any material misrepresentation in the application for the license;

2. The licensee or any officer, partner, member or key management personnel has been convicted of fraudulent or dishonest

practices, is subject to a final administrative action or is otherwise shown to be untrustworthy or incompetent;

3. The viatical settlement provider demonstrates a pattern of unreasonable payments to viators;

4. The licensee or any officer, partner, member or key management personnel has been found guilty of, or has pleaded guilty or nolo contendere to, any felony, or to a misdemeanor involving fraud or moral turpitude, regardless of whether a judgment of conviction has been entered by the court;

5. The viatical settlement provider has entered into any viatical settlement contract that has not been approved pursuant to the Viatical Settlements Act of 2008;

6. The viatical settlement provider has failed to honor contractual obligations set out in a viatical settlement contract;

7. The licensee no longer meets the requirements for initial licensure;

8. The viatical settlement provider has assigned, transferred or pledged a viaticated policy to a person other than a viatical settlement provider licensed in this state, viatical settlement purchaser, an accredited investor or qualified institutional buyer as defined respectively in Rule 501(a) or Rule 144A promulgated under the Federal Securities Act of 1933, as amended, financing entity, special purpose entity, or related provider trust; or

9. The licensee or any officer, partner, member or key management personnel has violated any provision of the Viatical Settlements Act of 2008.

B. The Commissioner may suspend, revoke or refuse to renew the license of a viatical settlement broker or a life insurance producer operating as a viatical settlement broker pursuant to the Viatical Settlements Act of 2008 if the Commissioner finds that the viatical settlement broker or life insurance producer has violated the provisions of the Viatical Settlements Act of 2008 or has otherwise engaged in bad-faith conduct with one or more viators.

C. If the Commissioner denies a license application or suspends, revokes or refuses to renew the license of a viatical settlement provider, viatical settlement broker or suspends, revokes, or refuses to renew a license of a life insurance producer operating as a viatical settlement broker pursuant to the Viatical Settlements Act of 2008 the Commissioner shall conduct a hearing in accordance with the Administrative Procedures Act.

Added by Laws 2008, c. 183, § 4, eff. Nov. 1, 2008.

§36-4055.5. Filing of forms - Disapproval by Commissioner.

A person shall not use a viatical settlement contract form or provide to a viator a disclosure statement form in this state unless first filed with and approved by the Insurance Commissioner. The Commissioner shall disapprove a viatical settlement contract form or

disclosure statement form if, in the Commissioner's opinion, the contract or provisions contained therein fail to meet the requirements of Sections 8, 9 and 12 and subsection B of Section 13 of this act or are unreasonable, contrary to the interests of the public, or otherwise misleading or unfair to the viator. At the Commissioner's discretion, the Commissioner may require the submission of advertising material.

Added by Laws 2008, c. 183, § 5, eff. Nov. 1, 2008.

§36-4055.6. Annual statement - Disclosure of insured's identity or information.

A. Each viatical settlement provider shall file with the Insurance Commissioner on or before March 1 of each year an annual statement containing information as the Commissioner may prescribe by regulation. In addition to any other requirements, for any policy settled within five (5) years of the date of issuance of the policy, the annual statement shall specify the total number, aggregate face amount and life settlement proceeds of policies settled during the immediately preceding calendar year, together with a breakdown of the information by policy-issue year. The information shall be limited to only those transactions where the viator is a resident of this state. Individual transaction data regarding the business of viatical settlements or data that could compromise the privacy of personal, financial and health information of the viator or insured shall be filed with the Commissioner on a confidential basis.

B. Except as otherwise allowed or required by law, a viatical settlement provider, viatical settlement broker, insurance company, insurance producer, information bureau, rating agency or company, or any other person with actual knowledge of an insured's identity, shall not disclose that identity as an insured, or the insured's financial or medical information to any other person unless the disclosure:

1. Is necessary to effect a viatical settlement between the viator and a viatical settlement provider and the viator and insured have provided prior written consent to the disclosure;

2. Is provided in response to an investigation or examination by the Commissioner or any other governmental officer or agency or pursuant to the requirements of subsection C of Section 13 of this act;

3. Is a term of or condition to the transfer of a policy by one viatical settlement provider to another viatical settlement provider;

4. Is necessary to permit a financing entity, related provider trust or special purpose entity to finance the purchase of policies by a viatical settlement provider and the viator and insured have provided prior written consent to the disclosure;

5. Is necessary to allow the viatical settlement provider or viatical settlement broker or their authorized representatives to make contacts for the purpose of determining health status; or

6. Is required to purchase stop loss coverage or financial guaranty insurance.

Added by Laws 2008, c. 183, § 6, eff. Nov. 1, 2008.

§36-4055.7. Examination of licensees - Records retention - Confidentiality - Appointment of examiner - Liability.

A. 1. The Insurance Commissioner may conduct an examination under the Viatical Settlements Act of 2008 of a licensee as often as the Commissioner in his or her discretion deems appropriate after considering the factors set forth in this paragraph. In scheduling and determining the nature, scope, and frequency of the examinations, the Commissioner shall consider such matters as the consumer complaints, results of financial statement analyses and ratios, changes in management or ownership, actuarial opinions, report of independent certified public accountants, and other relevant criteria as determined by the Commissioner.

2. For purposes of completing an examination of a licensee under the Viatical Settlements Act of 2008, the Commissioner may examine or investigate any person, or the business of any person, insofar as the examination or investigation is, in the sole discretion of the Commissioner, necessary or material to the examination of the licensee.

3. In lieu of an examination under the Viatical Settlements Act of 2008 of any foreign or alien licensee licensed in this state, the Commissioner may, at the Commissioner's discretion, accept an examination report on the licensee as prepared by the Commissioner for the licensee's state of domicile or port-of-entry state.

4. As far as practical, the examination of a foreign or alien licensee shall be made in cooperation with the insurance supervisory officials of other states in which the licensee transacts business.

B. 1. A person required to be licensed by the Viatical Settlements Act of 2008 shall for five (5) years for all settled policies and for two (2) years for all policies which are not settled retain copies of all:

- a. proposed, offered or executed contracts, purchase agreements, underwriting documents, policy forms, and applications from the date of the proposal, offer or execution of the contract or purchase agreement, whichever is later,
- b. all checks, drafts, electronic payment or other evidence and documentation related to the payment, transfer, deposit or release of funds from the date of the transaction, and

c. all other records and documents related to the requirements of the Viatical Settlements Act of 2008.

2. This subsection does not relieve a person of the obligation to produce these documents to the Commissioner after the retention period has expired if the person has retained the documents.

3. Records required to be retained by this subsection must be legible and complete and may be retained in paper, photograph, microprocess, magnetic, mechanical, or electronic media, or by any process that accurately reproduces or forms a durable medium for the reproduction of a record.

C. 1. Upon determining that an examination should be conducted, the Commissioner shall issue an examination warrant appointing one or more examiners to perform the examination and instructing them as to the scope of the examination. In conducting the examination, the examiner shall observe those guidelines and procedures set forth in the Examiners Handbook adopted by the National Association of Insurance Commissioners (NAIC). The Commissioner may also employ such other guidelines or procedures as the Commissioner may deem appropriate.

2. Every licensee or person from whom information is sought, its officers, directors and agents shall provide to the examiners timely, convenient and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents, assets and computer or other recordings relating to the property, assets, business and affairs of the licensee being examined. The officers, directors, employees and agents of the licensee or person shall facilitate the examination and aid in the examination so far as it is in their power to do so. The refusal of a licensee, by its officers, directors, employees or agents, to submit to examination or to comply with any reasonable written request of the Commissioner shall be grounds for suspension or refusal of, or nonrenewal of any license or authority held by the licensee to engage in the viatical settlement business or other business subject to the Commissioner's jurisdiction. Any proceedings for suspension, revocation or refusal of any license or authority shall be conducted in accordance with the Administrative Procedures Act.

3. The Commissioner shall have the power to issue subpoenas, to administer oaths and to examine under oath any person as to any matter pertinent to the examination. Upon the failure or refusal of a person to obey a subpoena, the Commissioner may petition a court of competent jurisdiction, and upon proper showing, the Court may enter an order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order shall be punishable as contempt of court.

4. When making an examination under the Viatical Settlements Act of 2008, the Commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants or

other professionals and specialists as examiners, the reasonable cost of which shall be borne by the licensee that is the subject of the examination.

5. Nothing contained in the Viatical Settlements Act of 2008 shall be construed to limit the Commissioner's authority to terminate or suspend an examination in order to pursue other legal or regulatory action pursuant to the insurance laws of this state. Findings of fact and conclusions made pursuant to any examination shall be prima facie evidence in any legal or regulatory action.

6. Nothing contained in the Viatical Settlements Act of 2008 shall be construed to limit the Commissioner's authority to use and, if appropriate, to make public any final or preliminary examination report, any examiner or licensee workpapers or other documents, or any other information discovered or developed during the course of any examination in the furtherance of any legal or regulatory action which the Commissioner may, in his or her sole discretion, deem appropriate.

D. 1. Examination reports shall be comprised of only facts appearing upon the books, records or other documents of the licensee, its agents or other persons examined, or as ascertained from the testimony of its officers or agents or other persons examined concerning its affairs, and such conclusions and recommendations as the examiners find reasonably warranted from the facts.

2. No later than sixty (60) days following completion of the examination, the examiner in charge shall file with the Commissioner a verified written report of examination under oath. Upon receipt of the verified report, the Commissioner shall transmit the report to the licensee examined, together with a notice that shall afford the licensee examined a reasonable opportunity of not more than thirty (30) days to make a written submission or rebuttal with respect to any matters contained in the examination report.

3. In the event the Commissioner determines that regulatory action is appropriate as a result of an examination, the Commissioner may initiate any proceedings or actions provided by law.

E. 1. Names and individual identification data for all viators shall be considered private and confidential information and shall not be disclosed by the Commissioner, unless required by law.

2. Except as otherwise provided in the Viatical Settlements Act of 2008, all examination reports, working papers, recorded information, documents and copies thereof produced by, obtained by or disclosed to the Commissioner or any other person in the course of an examination made under the Viatical Settlements Act of 2008, or in the course of analysis or investigation by the Commissioner of the financial condition or market conduct of a licensee shall be confidential by law and privileged, shall not be subject to the

Oklahoma Open Records Act, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. The Commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as part of the Commissioner's official duties.

3. Documents, materials or other information, including, but not limited to, all working papers, and copies thereof, in the possession or control of the NAIC and its affiliates and subsidiaries shall be confidential by law and privileged, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action if they are:

- a. created, produced or obtained by or disclosed to the NAIC and its affiliates and subsidiaries in the course of assisting an examination made under this act, or assisting a Commissioner in the analysis or investigation of the financial condition or market conduct of a licensee, or
- b. disclosed to the NAIC and its affiliates and subsidiaries under paragraph 4 of this subsection by a Commissioner.

For the purposes of paragraph 2 of this subsection, "act" means the law of another state or jurisdiction that is substantially similar to the Viatical Settlements Act of 2008.

4. Neither the Commissioner nor any person that received the documents, material or other information while acting under the authority of the Commissioner, including the NAIC and its affiliates and subsidiaries, shall be permitted to testify in any private civil action concerning any confidential documents, materials or information subject to paragraph 1 of this subsection.

5. In order to assist in the performance of the Commissioner's duties, the Commissioner:

- a. may share documents, materials or other information, including the confidential and privileged documents, materials or information subject to paragraph 1 of this subsection, with other state, federal and international regulatory agencies, with the NAIC and its affiliates and subsidiaries, and with state, federal and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material, communication or other information, and
- b. may receive documents, materials, communications or information, including otherwise confidential and privileged documents, materials or information, from the NAIC and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other

foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information.

6. No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the Commissioner under this section or as a result of sharing as authorized in paragraph 5 of this subsection.

7. A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this subsection shall be available and enforced in any proceeding in, and in any court of, this state.

8. Nothing contained in the Viatical Settlements Act of 2008 shall prevent or be construed as prohibiting the Commissioner from disclosing the content of an examination report, preliminary examination report or results, or any matter relating thereto, to the Commissioner of any other state or country, or to law enforcement officials of this or any other state or agency of the federal government at any time or to the NAIC, so long as such agency or office receiving the report or matters relating thereto agrees in writing to hold it confidential and in a manner consistent with the Viatical Settlements Act of 2008.

F. 1. An examiner may not be appointed by the Commissioner if the examiner, either directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in any person subject to examination under the Viatical Settlements Act of 2008. This section shall not be construed to automatically preclude an examiner from being:

- a. a viator,
- b. an insured in a viaticated insurance policy, or
- c. a beneficiary in an insurance policy that is proposed to be viaticated.

2. Notwithstanding the requirements of this paragraph, the Commissioner may retain from time to time, on an individual basis, qualified actuaries, certified public accountants, or other similar individuals who are independently practicing their professions, even though these persons may from time to time be similarly employed or retained by persons subject to examination under the Viatical Settlements Act of 2008.

G. 1. No cause of action shall arise nor shall any liability be imposed against the Commissioner, the Commissioner's authorized representatives or any examiner appointed by the Commissioner for any statements made or conduct performed in good faith while carrying out the provisions of the Viatical Settlements Act of 2008.

2. No cause of action shall arise, nor shall any liability be imposed against any person for the act of communicating or delivering information or data to the Commissioner or the Commissioner's authorized representative or examiner pursuant to an examination made under the Viatical Settlements Act of 2008, if the act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive. This paragraph does not abrogate or modify in any way any common law or statutory privilege or immunity heretofore enjoyed by any person identified in paragraph 1 of this subsection.

3. A person identified in paragraph 1 or 2 of this subsection shall be entitled to an award of attorney fees and costs if he or she is the prevailing party in a civil cause of action for libel, slander or any other relevant tort arising out of activities in carrying out the provisions of this act and the party bringing the action was not substantially justified in doing so. For purposes of this section a proceeding is "substantially justified" if it had a reasonable basis in law or fact at the time that it was initiated.

H. The Commissioner may investigate suspected fraudulent viatical settlement acts and persons engaged in the business of viatical settlements.

Added by Laws 2008, c. 183, § 7, eff. Nov. 1, 2008. Amended by Laws 2008, c. 344, § 4, eff. Nov. 1, 2008; Laws 2021, c. 478, § 24, emerg. eff. May 12, 2021.

§36-4055.8. Disclosures to viator.

A. With each application for a viatical settlement, a viatical settlement provider or viatical settlement broker shall provide the viator with at least the following disclosures no later than the time the application for the viatical settlement contract is signed by all parties. The disclosures shall be provided in a separate document that is signed by the viator and the viatical settlement provider or viatical settlement broker, and shall provide the following information:

1. There are possible alternatives to viatical settlement contracts including any accelerated death benefits or policy loans offered under the viator's life insurance policy;

2. That a viatical settlement broker represents exclusively the viator, and not the insurer or the viatical settlement provider, and owes a fiduciary duty to the viator, including a duty to act according to the viator's instructions and in the best interest of the viator;

3. Some or all of the proceeds of the viatical settlement may be taxable under federal income tax and state franchise and income taxes, and assistance should be sought from a professional tax advisor;

4. Proceeds of the viatical settlement could be subject to the claims of creditors;

5. Receipt of the proceeds of a viatical settlement may adversely affect the viator's eligibility for Medicaid or other government benefits or entitlements, and advice should be obtained from the appropriate government agencies;

6. The viator has the right to rescind a viatical settlement contract before the earlier of thirty (30) calendar days after the date upon which the viatical settlement contract is executed by all parties or fifteen (15) calendar days after the viatical settlement proceeds have been paid to the viator. Rescission, if exercised by the viator, is effective only if both notice of the rescission is given, and the viator repays all proceeds and any premiums, loans and loan interest paid on account of the viatical settlement within the rescission period. If the insured dies during the rescission period, the viatical settlement contract shall be deemed to have been rescinded, subject to repayment by the viator or the viator's estate of all viatical settlement proceeds and any premiums, loans and loan interest on the viatical settlement within sixty (60) days of the insured's death;

7. Funds will be sent to the viator within three (3) business days after the viatical settlement provider has received the insurer's or group administrator's written acknowledgment that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated;

8. Entering into a viatical settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy or certificate, to be forfeited by the viator. Assistance should be sought from a financial adviser;

9. Disclosure to a viator shall include distribution of a brochure describing the process of viatical settlements. The National Association of Insurance Commissioner's (NAIC's) form for the brochure shall be used unless another form is developed or approved by the Insurance Commissioner;

10. The disclosure document shall contain the following language: "All medical, financial or personal information solicited or obtained by a viatical settlement provider or viatical settlement broker about an insured, including the insured's identity or the identity of family members, a spouse or a significant other may be disclosed as necessary to effect the viatical settlement between the viator and the viatical settlement provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every two (2) years."; and

11. Following execution of a viatical contract, the insured may be contacted for the purpose of determining the insured's health status and to confirm the insured's residential or business street address and telephone number, or as otherwise provided in the Viatical Settlements Act of 2008. This contact shall be limited to once every three (3) months if the insured has a life expectancy of more than one (1) year, and no more than once per month if the insured has a life expectancy of one (1) year or less. All such contacts shall be made only by a viatical settlement provider licensed in the state in which the viator resided at the time of the viatical settlement, or by the authorized representative of a duly licensed viatical settlement provider.

B. A viatical settlement provider shall provide the viator with at least the following disclosures no later than the date the viatical settlement contract is signed by all parties. The disclosures shall be conspicuously displayed in the viatical settlement contract or in a separate document signed by the viator and provide the following information:

1. The affiliation, if any, between the viatical settlement provider and the issuer of the insurance policy to be viaticated;

2. The document shall include the name, business address and telephone number of the viatical settlement provider;

3. Any affiliations or contractual arrangements between the viatical settlement provider and the viatical settlement purchaser;

4. If an insurance policy to be viaticated has been issued as a joint policy or involves family riders or any coverage of a life other than the insured under the policy to be viaticated, the viator shall be informed of the possible loss of coverage on the other lives under the policy and shall be advised to consult with his or her insurance producer or the insurer issuing the policy for advice on the proposed viatical settlement;

5. State the dollar amount of the current death benefit payable to the viatical settlement provider under the policy or certificate. If known, the viatical settlement provider shall also disclose the availability of any additional guaranteed insurance benefits, the dollar amount of any accidental death and dismemberment benefits under the policy or certificate and the extent to which the viator's interest in those benefits will be transferred as a result of the viatical settlement contract; and

6. State whether the funds will be escrowed with an independent third party during the transfer process, and if so, provide the name, business address, and telephone number of the independent third-party escrow agent, and the fact that the viator or owner may inspect or receive copies of the relevant escrow or trust agreements or documents.

C. A viatical settlement broker shall provide the viator with at least the following disclosures no later than the date the

viatical settlement contract is signed by all parties. The disclosures shall be conspicuously displayed in the viatical settlement contract or in a separate document signed by the viator and provide the following information:

1. The name, business address and telephone number of the viatical settlement broker;

2. A full, complete and accurate description of all offers, counter-offers, acceptances and rejections relating to the proposed viatical settlement contract; and

3. A written disclosure of any affiliations or contractual arrangements between the viatical settlement broker and any person making an offer in connection with the proposed viatical settlement contracts.

D. If the viatical settlement provider transfers ownership or changes the beneficiary of the insurance policy, the provider shall communicate in writing the change in ownership or beneficiary to the insured within twenty (20) days after the change.

E. A viatical settlement provider or its viatical settlement investment agent shall provide the viatical settlement purchaser with at least the following disclosures no later than at the time of the assignment, transfer or sale of all or a portion of an insurance policy. The disclosures shall be contained in a document signed by the viatical settlement purchaser and viatical settlement provider or viatical settlement investment agent, and shall make the following disclosures to the viatical settlement purchaser:

1. Disclose all the life expectancy certifications obtained by the provider in the process of determining the price paid to the viator;

2. State whether premium payments or other costs related to the policy have been escrowed. If escrowed, state the date upon which the escrowed funds will be depleted and whether the purchaser will be responsible for payment of premiums thereafter and, if so, the amount of the premiums;

3. State whether premium payments or other costs related to the policy have been waived. If waived, disclose whether the investor will be responsible for payment of the premiums if the insurer that wrote the policy terminates the waiver after purchase and the amount of those premiums;

4. Disclose the type of policy offered or sold, i.e., whole life, term life, universal life or a group policy certificate, any additional benefits contained in the policy, and the current status of the policy;

5. If the policy is term insurance, disclose the special risks associated with term insurance including, but not limited to, the purchaser's responsibility for additional premiums if the viator continues the term policy at the end of the current term;

6. State whether the policy is contestable;

7. State whether the insurer that wrote the policy has any additional rights that could negatively affect or extinguish the purchaser's rights under the viatical settlement contract, what these rights are, and under what conditions these rights are activated; and

8. State the name and address of the person responsible for monitoring the insured's condition. Describe how often the monitoring of the insured's condition is done, how the date of death is determined, and how and when this information will be transmitted to the purchaser.

Added by Laws 2008, c. 183, § 8, eff. Nov. 1, 2008. Amended by Laws 2008, c. 344, § 5, eff. Nov. 1, 2008.

§36-4055.9. Procedures for entering into contracts - Rescission - Escrow - Minimum discounts - Contract to determine health status.

A. 1. A viatical settlement provider entering into a viatical settlement contract shall first obtain:

- a. if the viator is the insured, a written statement from a licensed attending physician that the viator is of sound mind and under no constraint or undue influence to enter into a viatical settlement contract, and
- b. a document in which the insured consents to the release of his or her medical records to a licensed viatical settlement provider, viatical settlement broker and the insurance company that issued the life insurance policy covering the life of the insured.

2. Within twenty (20) days after a viator executes documents necessary to transfer any rights under an insurance policy or within twenty (20) days of entering any agreement, option, promise or any other form of understanding, expressed or implied, to viaticate the policy, the viatical settlement provider shall give written notice to the insurer that issued that insurance policy that the policy has or will become a viaticated policy. The notice shall be accompanied by the documents required by paragraph 3 of this subsection.

3. Within twenty (20) days after a viator executes documents necessary to transfer any rights under an insurance policy or within twenty (20) days of entering any agreement, option, promise or any other form of understanding, expressed or implied, to viaticate the policy, the viatical provider shall deliver a copy of the medical release required under subparagraph b of paragraph 1 of this subsection, a copy of the viator's application for the viatical settlement contract, the notice required under paragraph 2 of this subsection and a request for verification of coverage to the insurer that issued the life policy that is the subject of the viatical transaction. The National Association of Insurance Commissioner's (NAIC's) form for verification of coverage shall be used unless

another form is developed and approved by the Insurance Commissioner.

4. The insurer shall respond to a request for verification of coverage submitted on an approved form by a viatical settlement provider or viatical settlement broker within thirty (30) calendar days of the date the request is received and shall indicate whether, based on the medical evidence and documents provided, the insurer intends to pursue an investigation at this time regarding the validity of the insurance contract or possible fraud. The insurer shall accept a request for verification of coverage made on an NAIC form, any form agreed upon by the insurer and the requestor, or any other form approved by the Commissioner. The insurer shall accept an original or facsimile or electronic copy of such request and any accompanying authorization signed by the viator. Failure by the insurer to meet its obligations under this subsection shall be a violation of subsection C of Section 10 and Section 15 of Enrolled Senate Bill No. 1980 of the 2nd Session of the 51st Oklahoma Legislature.

5. Prior to or at the time of execution of the viatical settlement contract, the viatical settlement provider shall obtain a witnessed document in which the viator consents to the viatical settlement contract, represents that the viator has a full and complete understanding of the viatical settlement contract, that he or she has a full and complete understanding of the benefits of the life insurance policy, acknowledges that he or she is entering into the viatical settlement contract freely and voluntarily and, for persons with a terminal or chronic illness or condition, acknowledges that the insured has a terminal or chronic illness and that the terminal or chronic illness or condition was diagnosed after the life insurance policy was issued.

6. The insurer shall not unreasonably delay effecting change of ownership or beneficiary with any life settlement contract entered into in this state or with a resident of this state.

7. If a viatical settlement broker performs any of these activities required of the viatical settlement provider, the provider is deemed to have fulfilled the requirements of this section.

B. All medical information solicited or obtained by any licensee shall be subject to the applicable provisions of state law relating to confidentiality of medical information.

C. All viatical settlement contracts entered into in this state shall provide the viator with an absolute right to rescind the contract before the earlier of thirty (30) calendar days after the date upon which the viatical settlement contract is executed by all parties or fifteen (15) calendar days after the viatical settlement proceeds have been sent to the viator. Rescission by the viator may be conditioned upon the viator both giving notice and repaying to

the viatical settlement provider within the rescission period all proceeds of the settlement and any premiums, loans and loan interest paid by or on behalf of the viatical settlement provider in connection with or as a consequence of the viatical settlement. If the insured dies during the rescission period, the viatical settlement contract shall be deemed to have been rescinded, subject to repayment to the viatical settlement provider or purchaser of all viatical settlement proceeds, and any premiums, loans and loan interest that have been paid by the viatical settlement provider or purchaser, which shall be paid within sixty (60) calendar days of the death of the insured. In the event of any rescission, if the viatical settlement provider has paid commissions or other compensation to a viatical settlement broker in connection with the rescinded transaction, the viatical settlement broker shall refund all such commissions and compensation to the viatical settlement provider within five (5) business days following receipt of written demand from the viatical settlement provider, which demand shall be accompanied by either the viator's notice of rescission if rescinded at the election of the viator, or notice of the death of the insured if rescinded by reason of the death of the insured within the applicable rescission period.

D. The viatical settlement provider shall instruct the viator to send the executed documents required to effect the change in ownership, assignment or change in beneficiary directly to the independent escrow agent. Within three (3) business days after the date the escrow agent receives the document or from the date the viatical settlement provider receives the documents, if the viator erroneously provides the documents directly to the provider, the provider shall pay or transfer the proceeds of the viatical settlement into an escrow or trust account maintained in a state- or federally-chartered financial institution whose deposits are insured by the Federal Deposit Insurance Corporation (FDIC). Upon payment of the settlement proceeds into the escrow account, the escrow agent shall deliver the original change in ownership, assignment or change in beneficiary forms to the viatical settlement provider or related provider trust or other designated representative of the viatical settlement provider. Upon the escrow agent's receipt of the acknowledgment of the properly completed transfer of ownership, assignment or designation of beneficiary from the insurance company, the escrow agent shall pay the settlement proceeds to the viator.

E. Failure to tender consideration to the viator for the viatical settlement contract within the time set forth in the disclosure pursuant to paragraph 7 of subsection A of Section 8 of Enrolled Senate Bill No. 1980 of the 2nd Session of the 51st Oklahoma Legislature renders the viatical settlement contract voidable by the viator for lack of consideration until the time consideration is tendered to and accepted by the viator. Funds

shall be deemed sent by a viatical settlement provider to a viator as of the date that the escrow agent either releases funds for wire transfer to the viator, places a check for delivery to the viator via United States Postal Service or other nationally recognized delivery service or make an electronic payment to the viator.

F. In order to assure that a viator, at the time of the viatical settlement has a life expectancy of less than two (2) years, receives reasonable return for viaticating an insurance policy, the following shall be minimum discounts:

Insured's Life Expectancy	Minimum Percentage of Face Value Less Outstanding Loans Received By Viator
Less than six (6) months	80%
At least six (6) but less than twelve (12) months	70%
At least twelve (12) but less than eighteen (18) months	65%
At least eighteen (18) months but less than twenty-four (24) months	60%

G. Contacts with the insured for the purpose of determining the health status of the insured by the viatical settlement provider or viatical settlement broker after the viatical settlement has occurred shall only be made by a viatical settlement provider or broker licensed in this state or its authorized representatives and shall be limited to once every three (3) months for insureds with a life expectancy of more than one (1) year, and to no more than once per month for insureds with a life expectancy of one (1) year or less. The provider or broker shall explain the procedure for these contacts at the time the viatical settlement contract is entered into. The limitations set forth in this subsection shall not apply to any contacts with an insured for reasons other than determining the insured's health status. Viatical settlement providers and viatical settlement brokers shall be responsible for the actions of their authorized representatives.

Added by Laws 2008, c. 183, § 9, eff. Nov. 1, 2008. Amended by Laws 2008, c. 344, § 6, eff. Nov. 1, 2008; Laws 2021, c. 478, § 25, emerg. eff. May 12, 2021.

§36-4055.10. Contracts within two years of issuance of insurance policy or certificate - Requests for verification of coverage or transfer of policy.

A. It is a violation of the Viatical Settlements Act of 2008 for any person to enter into a viatical settlement contract at any time prior to the application or issuance of a policy which is the subject of viatical settlement contract or within a two-year period commencing with the date of issuance of the insurance policy or certificate unless the viator certifies to the viatical settlement

provider that one or more of the following conditions have been met within the two-year period:

1. The policy was issued upon the viator's exercise of conversion rights arising out of a group or individual policy, provided the total of the time covered under the conversion policy plus the time covered under the prior policy is at least twenty-four (24) months. The time covered under a group policy shall be calculated without regard to any change in insurance carriers, provided the coverage has been continuous and under the same group sponsorship; or

2. The viator submits independent evidence to the viatical settlement provider that one or more of the following conditions have been met within the two-year period:

- a. the viator or insured is terminally or chronically ill,
- b. the viator's spouse dies,
- c. the viator divorces his or her spouse,
- d. the viator retires from full-time employment,
- e. the viator becomes physically or mentally disabled and a physician determines that the disability prevents the viator from maintaining full-time employment,
- f. a final order, judgment or decree is entered by a court of competent jurisdiction, on the application of a creditor of the viator, adjudicating the viator bankrupt or insolvent, or approving a petition seeking reorganization of the viator or appointing a receiver, trustee or liquidator to all or a substantial part of the viator's assets, or
- g. the viator involuntarily experiences a significant decrease in income that is unexpected and that also reasonably impairs the reasonable ability of the viator to pay the policy premiums.

B. Copies of the independent evidence described in paragraph 2 of subsection A of this section and documents required by subsection A of Section 9 of this act shall be submitted to the insurer when the viatical settlement provider or other party entering into a viatical settlement contract with a viator submits a request to the insurer for verification of coverage. The copies shall be accompanied by a letter of attestation from the viatical settlement provider that the copies are true and correct copies of the documents received by the viatical settlement provider.

C. If the viatical settlement provider submits to the insurer a copy of the owner or insured's certification described in and the independent evidence required by paragraph 2 of subsection A of this section when the provider submits a request to the insurer to effect the transfer of the policy or certificate to the viatical settlement provider, the copy shall be deemed to conclusively establish that

the viatical settlement contract satisfies the requirements of this section and the insurer shall timely respond to the request.

D. No insurer may, as a condition of responding to a request for verification of coverage or effecting the transfer of a policy pursuant to a viatical settlement contract, require that the viator, insured, viatical settlement provider or viatical settlement broker sign any forms, disclosures, consent or waiver form that has not been expressly approved by the Insurance Commissioner for use in connection with viatical settlement contracts in this state.

E. Upon receipt of a properly completed request for change of ownership or beneficiary of a policy, the insurer shall respond in writing within thirty (30) calendar days with written acknowledgement confirming that the change has been effected or specifying the reasons why the requested change cannot be processed. The insurer shall not unreasonably delay effecting change of ownership or beneficiary and shall not otherwise seek to interfere with any viatical settlement contract lawfully entered into in this state.

Added by Laws 2008, c. 183, § 10, eff. Nov. 1, 2008.

§36-4055.11. Fraudulent viatical settlement acts - Filing of advertising - "Free" insurance - Additional consideration - Emphasis on settling policy prohibited.

A. With respect to any viatical settlement contract or insurance policy, no viatical settlement broker knowingly shall solicit an offer from, effectuate a viatical settlement with or make a sale to any viatical settlement provider, viatical settlement purchaser, financing entity or related provider trust that is controlling, controlled by, or under common control with such viatical settlement broker unless the relationship is disclosed to the viator.

B. With respect to any viatical settlement contract or insurance policy, no viatical settlement provider knowingly may enter into a viatical settlement contract with a viator, if, in connection with such viatical settlement contract, anything of value will be paid to a viatical settlement broker that is controlling, controlled by, or under common control with such viatical settlement provider or the viatical settlement purchaser, financing entity or related provider trust that is involved in such viatical settlement contract unless the relationship is disclosed to the viator.

C. A violation of subsection A or B of this section shall be deemed a fraudulent viatical settlement act.

D. No viatical settlement provider shall enter into a viatical settlement contract unless the viatical settlement promotional, advertising and marketing materials, as may be prescribed by regulation, have been filed with the Insurance Commissioner. In no event shall any marketing materials expressly reference that the

insurance is "free" for any period of time. The inclusion of any reference in the marketing materials that would cause a viator to reasonably believe that the insurance is free for any period of time shall be considered a violation of the Viatical Settlements Act of 2008.

E. No life insurance producer, insurance company, viatical settlement broker, viatical settlement provider or viatical settlement investment agent shall make any statement or representation to the applicant or policyholder in connection with the sale or financing of a life insurance policy to the effect that the insurance is free or without cost to the policyholder for any period of time unless provided in the policy.

F. No person providing premium financing shall receive any proceeds, fees or other consideration from the policy or owner of the policy that is in addition to the amounts required to pay principal, interest, and any other reasonable costs or expenses in type and amount incurred by the lender or borrower in connection with the premium finance agreement, except for the event of a default, unless either the default on the loan or transfer of the policy in connection with the default occurs pursuant to an agreement or understanding with any other person for the purpose of evading regulation under this act. Any payments, charges, fees or other amounts received by a person providing premium financing in violation of this subsection shall be remitted to the original owner of the policy or to the estate of the owner if the owner is deceased at the time of the determination of the overpayment.

G. No person shall issue, solicit, market or otherwise promote the purchase of an insurance policy for the purpose of, or with an emphasis on, settling the policy.

Added by Laws 2008, c. 183, § 11, eff. Nov. 1, 2008. Amended by Laws 2008, c. 344, § 7, eff. Nov. 1, 2008.

§36-4055.12. Advertisement of contracts, products or services - Guidelines and standards.

A. The purpose of this section is to provide prospective viators with clear and unambiguous statements in the advertisement of viatical settlements and to assure the clear, truthful and adequate disclosure of the benefits, risks, limitations and exclusions of any viatical settlement contract. This purpose is intended to be accomplished by the establishment of guidelines and standards of permissible and impermissible conduct in the advertising of viatical settlements to assure that product descriptions are presented in a manner that prevents unfair, deceptive or misleading advertising and is conducive to accurate presentation and description of viatical settlements through the advertising media and material used by viatical settlement licensees.

B. This section shall apply to any advertising of viatical settlement contracts or related products or services intended for dissemination in this state, including Internet advertising viewed by persons located in this state. Where disclosure requirements are established pursuant to federal regulation, this section shall be interpreted so as to minimize or eliminate conflict with federal regulation wherever possible.

C. Every viatical settlement licensee shall establish and at all times maintain a system of control over the content, form and method of dissemination of all advertisements of its contracts, products and services. All advertisements, regardless of by whom written, created, designed or presented, shall be the responsibility of the viatical settlement licensees, as well as the individual who created or presented the advertisement. A system of control shall include regular routine notification, at least once a year, to agents and others authorized by the viatical settlement licensee who disseminate advertisements of the requirements and procedures for approval prior to the use of any advertisements not furnished by the viatical settlement licensee.

D. Advertisements shall be truthful and not misleading in fact or by implication. The form and content of an advertisement of a viatical settlement contract shall be sufficiently complete and clear so as to avoid deception. It shall not have the capacity or tendency to mislead or deceive. Whether an advertisement has the capacity or tendency to mislead or deceive shall be determined by the Insurance Commissioner from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence within the segment of the public to which it is directed.

E. The information required to be disclosed under this section shall not be minimized, rendered obscure, or presented in an ambiguous fashion or intermingled with the text of the advertisement so as to be confusing or misleading.

1. An advertisement shall not omit material information or use words, phrases, statements, references or illustrations if the omission or use has the capacity, tendency or effect of misleading or deceiving viators as to the nature or extent of any benefit, loss covered, premium payable, or state or federal tax consequence. The fact that the viatical settlement contract offered is made available for inspection prior to consummation of the sale, or an offer is made to refund the payment if the viator is not satisfied or that the viatical settlement contract includes a "free look" period that satisfies or exceeds legal requirements, does not remedy misleading statements.

2. An advertisement shall not use the name or title of a life insurance company or a life insurance policy unless the advertisement has been approved by the insurer.

3. An advertisement shall not state or imply that interest charged on an accelerated death benefit or a policy loan is unfair, inequitable or in any manner an incorrect or improper practice.

4. The words "free", "no cost", "without cost", "no additional cost", "at no extra cost", or words of similar import shall not be used with respect to any benefit or service unless true. An advertisement may specify the charge for a benefit or a service or may state that a charge is included in the payment or use other appropriate language.

5. Testimonials, appraisals or analysis used in advertisements must be genuine; represent the current opinion of the author; be applicable to the viatical settlement contract, product or service advertised, if any; and be accurately reproduced with sufficient completeness to avoid misleading or deceiving prospective viators as to the nature or scope of the testimonials, appraisal, analysis or endorsement. In using testimonials, appraisals or analysis, a licensee under the Viatical Settlements Act of 2008 makes as its own all the statements contained therein, and the statements are subject to all the provisions of this section.

- a. If the individual making a testimonial, appraisal, analysis or an endorsement has a financial interest in the party making use of the testimonial, appraisal, analysis or endorsement, either directly or through a related entity as a stockholder, director, officer, employee or otherwise, or receives any benefit directly or indirectly other than required union scale wages, that fact shall be prominently disclosed in the advertisement.
- b. An advertisement shall not state or imply that a viatical settlement contract, benefit or service has been approved or endorsed by a group of individuals, society, association or other organization unless that is the fact and unless any relationship between an organization and the viatical settlement licensee is disclosed. If the entity making the endorsement or testimonial is owned, controlled or managed by the viatical settlement licensee, or receives any payment or other consideration from the viatical settlement licensee for making an endorsement or testimonial, that fact shall be disclosed in the advertisement.
- c. When an endorsement refers to benefits received under a viatical settlement contract all pertinent information shall be retained for a period of five (5) years after its use.

F. An advertisement shall not contain statistical information unless it accurately reflects recent and relevant facts. The source of all statistics used in an advertisement shall be identified.

G. An advertisement shall not disparage insurers, viatical settlement providers, viatical settlement brokers, viatical settlement investment agents, insurance producers, policies, services or methods of marketing.

H. The name of the viatical settlement licensee shall be clearly identified in all advertisements about the licensee or its viatical settlement contract, products or services, and if any specific viatical settlement contract is advertised, the viatical settlement contract shall be identified either by form number or some other appropriate description. If an application is part of the advertisement, the name of the viatical settlement provider shall be shown on the application.

I. An advertisement shall not use a trade name, group designation, name of the parent company of a viatical settlement licensee, name of a particular division of the viatical settlement licensee, service mark, slogan, symbol or other device or reference without disclosing the name of the viatical settlement licensee, if the advertisement would have the capacity or tendency to mislead or deceive as to the true identity of the viatical settlement licensee, or to create the impression that a company other than the viatical settlement licensee would have any responsibility for the financial obligation under a viatical settlement contract.

J. An advertisement shall not use any combination of words, symbols or physical materials that by their content, phraseology, shape, color or other characteristics are so similar to a combination of words, symbols or physical materials used by a government program or agency or otherwise appear to be of such a nature that they tend to mislead prospective viators into believing that the solicitation is in some manner connected with a government program or agency.

K. An advertisement may state that a viatical settlement licensee is licensed in the state where the advertisement appears, provided it does not exaggerate that fact or suggest or imply that competing viatical settlement licensees may not be so licensed. The advertisement may ask the audience to consult the licensee's web site or contact the department of insurance to find out if the state requires licensing and, if so, whether the viatical settlement provider, viatical settlement broker is licensed.

L. An advertisement shall not create the impression that the viatical settlement provider, its financial condition or status, the payment of its claims or the merits, desirability, or advisability of its viatical settlement contracts are recommended or endorsed by any government entity.

M. The name of the actual licensee shall be stated in all of its advertisements. An advertisement shall not use a trade name, any group designation, name of any affiliate or controlling entity of the licensee, service mark, slogan, symbol or other device in a

manner that would have the capacity or tendency to mislead or deceive as to the true identity of the actual licensee or create the false impression that an affiliate or controlling entity would have any responsibility for the financial obligation of the licensee.

N. An advertisement shall not directly or indirectly create the impression that any division or agency of the state or of the federal government endorses, approves or favors:

1. Any viatical settlement licensee or its business practices or methods of operation;

2. The merits, desirability or advisability of any viatical settlement contract;

3. Any viatical settlement contract; or

4. Any life insurance policy or life insurance company.

O. If the advertiser emphasizes the speed with which the viatication will occur, the advertising must disclose the average time frame from completed application to the date of offer and from acceptance of the offer to receipt of the funds by the viator.

P. If the advertising emphasizes the dollar amounts available to viators, the advertising shall disclose the average purchase price as a percent of face value obtained by viators contracting with the licensee during the past six (6) months.

Added by Laws 2008, c. 183, § 12, eff. Nov. 1, 2008.

§36-4055.13. Prohibited acts - Warning statement - Provision of information on fraudulent acts - Liability - Antifraud initiatives.

A. 1. A person shall not commit a fraudulent viatical settlement act.

2. A person shall not knowingly or intentionally interfere with the enforcement of the provisions of the Viatical Settlements Act of 2008 or investigations of suspected or actual violations of the Viatical Settlements Act of 2008.

3. A person in the business of viatical settlements shall not knowingly or intentionally permit any person convicted of a felony involving dishonesty or breach of trust to participate in the business of viatical settlements.

B. 1. Viatical settlements contracts and applications for viatical settlements, regardless of the form of transmission, shall contain the following statement or a substantially similar statement:

"Any person who knowingly presents false information in an application for insurance or viatical settlement contract is guilty of a crime and may be subject to fines and confinement in prison."

2. The lack of a statement as required in paragraph 1 of this subsection does not constitute a defense in any prosecution for a fraudulent viatical settlement act.

C. 1. Any person engaged in the business of viatical settlements having knowledge or a reasonable suspicion that a

fraudulent viatical settlement act is being, will be or has been committed shall provide to the Insurance Commissioner such information as required by, and in a manner prescribed by, the Commissioner.

2. Any other person having knowledge or a reasonable belief that a fraudulent viatical settlement act is being, will be or has been committed may provide to the Commissioner the information required by, and in a manner prescribed by, the Commissioner.

D. 1. No civil liability shall be imposed on and no cause of action shall arise from a person's furnishing information concerning suspected, anticipated or completed fraudulent viatical settlement acts or suspected or completed fraudulent insurance acts, if the information is provided to or received from:

- a. the Commissioner or the Commissioner's employees, agents or representatives,
- b. federal, state or local law enforcement or regulatory officials or their employees, agents or representatives,
- c. a person involved in the prevention and detection of fraudulent viatical settlement acts or that person's agents, employees or representatives,
- d. the National Association of Insurance Commissioners (NAIC), National Association of Securities Dealers (NASD), the North American Securities Administrators Association (NASAA), or their employees, agents or representatives, or other regulatory body overseeing life insurance, viatical settlements, securities or investment fraud, or
- e. the life insurer that issued the life insurance policy covering the life of the insured.

2. Paragraph 1 of this subsection shall not apply to statements made with actual malice. In an action brought against a person for filing a report or furnishing other information concerning a fraudulent viatical settlement act, the party bringing the action shall plead specifically any allegation that paragraph 1 of this subsection does not apply because the person filing the report or furnishing the information did so with actual malice.

3. A person furnishing information as identified in paragraph 1 of this subsection shall be entitled to an award of attorney fees and costs if he or she is the prevailing party in a civil cause of action for libel, slander or any other relevant tort arising out of activities in carrying out the provisions of the Viatical Settlements Act of 2008 and the party bringing the action was not substantially justified in doing so. For purposes of this section a proceeding is "substantially justified" if it had a reasonable basis in law or fact at the time that it was initiated. However, such an

award does not apply to any person furnishing information concerning his or her own fraudulent viatical settlement acts.

4. This section does not abrogate or modify common law or statutory privileges or immunities enjoyed by a person described in paragraph 1 of this subsection.

E. 1. The documents and evidence provided pursuant to subsection D of this section or obtained by the Commissioner in an investigation of suspected or actual fraudulent viatical settlement acts shall be privileged and confidential and shall not be a public record and shall not be subject to discovery or subpoena in a civil or criminal action.

2. Paragraph 1 of this subsection does not prohibit release by the Commissioner of documents and evidence obtained in an investigation of suspected or actual fraudulent viatical settlement acts:

- a. in administrative or judicial proceedings to enforce laws administered by the Commissioner,
- b. to federal, state or local law enforcement or regulatory agencies, to an organization established for the purpose of detecting and preventing fraudulent viatical settlement acts or to the NAIC, or
- c. at the discretion of the Commissioner, to a person in the business of viatical settlements that is aggrieved by a fraudulent viatical settlement act.

3. Release of documents and evidence under paragraph 2 of this subsection does not abrogate or modify the privilege granted in paragraph 1 of this subsection.

F. This act shall not:

1. Preempt the authority or relieve the duty of other law enforcement or regulatory agencies to investigate, examine and prosecute suspected violations of law;

2. Prevent or prohibit a person from disclosing voluntarily information concerning viatical settlement fraud to a law enforcement or regulatory agency other than the Insurance Department;

3. Preempt, supersede, or limit any provision of any state securities law or any rule, order, or notice issued thereunder; or

4. Limit the powers granted elsewhere by the laws of this state to the Commissioner or an insurance fraud unit to investigate and examine possible violations of law and to take appropriate action against wrongdoers.

G. 1. Viatical settlement providers and viatical settlement brokers shall have in place antifraud initiatives reasonably calculated to detect, prosecute and prevent fraudulent viatical settlement acts. At the discretion of the Commissioner, the Commissioner may order, or a licensee may request and the Commissioner may grant, such modifications of the following required

initiatives as necessary to ensure an effective antifraud program. The modifications may be more or less restrictive than the required initiatives so long as the modifications may reasonably be expected to accomplish the purpose of this section.

2. Antifraud initiatives shall include:

- a. fraud investigators, who may be viatical settlement provider or viatical settlement broker employees or independent contractors, and
- b. an antifraud plan, which shall be submitted to the Commissioner. The antifraud plan shall include, but not be limited to:
 - (1) a description of the procedures for detecting and investigating possible fraudulent viatical settlement acts and procedures for resolving material inconsistencies between medical records and insurance applications,
 - (2) a description of the procedures for reporting possible fraudulent viatical settlement acts to the Commissioner,
 - (3) a description of the plan for antifraud education and training of underwriters and other personnel, and
 - (4) a description or chart outlining the organizational arrangement of the antifraud personnel who are responsible for the investigation and reporting of possible fraudulent viatical settlement acts and investigating unresolved material inconsistencies between medical records and insurance applications.

3. Antifraud plans submitted to the Commissioner shall be privileged and confidential and shall not be a public record and shall not be subject to discovery or subpoena in a civil or criminal action.

Added by Laws 2008, c. 183, § 13, eff. Nov. 1, 2008. Amended by Laws 2008, c. 344, § 8, eff. Nov. 1, 2008.

§36-4055.14. Injunction - Civil action - Cease and desist orders - Civil and criminal penalties.

A. In addition to the penalties and other enforcement provisions of the Viatical Settlements Act of 2008, if any person violates the Viatical Settlements Act of 2008 or any regulation implementing the Viatical Settlements Act of 2008, the Insurance Commissioner may seek an injunction in a court of competent jurisdiction and may apply for temporary and permanent orders that the Commissioner determines are necessary to restrain the person from committing the violation.

B. Any person damaged by the acts of a person in violation of the Viatical Settlements Act of 2008 may bring a civil action against the person committing the violation in a court of competent jurisdiction.

C. The Commissioner may issue, in accordance with the Administrative Procedures Act, a cease and desist order upon a person that violates any provision of the Viatical Settlements Act of 2008, any regulation or order adopted by the Commissioner, or any written agreement entered into with the Commissioner.

D. When the Commissioner finds that an activity in violation of the Viatical Settlements Act of 2008 presents an immediate danger to the public that requires an immediate final order, the Commissioner may issue an emergency cease and desist order reciting with particularity the facts underlying the findings. The emergency cease and desist order is effective immediately upon service of a copy of the order on the respondent and remains effective for ninety (90) days. If the Commissioner begins nonemergency cease and desist proceedings, the emergency cease and desist order remains effective, absent an order by a court of competent jurisdiction pursuant to the Administrative Procedures Act.

E. In addition to the penalties and other enforcement provisions of the Viatical Settlements Act of 2008, any person who violates the Viatical Settlements Act of 2008 is subject to civil penalties of up to Ten Thousand Dollars (\$10,000.00) per violation. Imposition of civil penalties shall be pursuant to an order of the Commissioner issued under Section 313 of Title 36 of the Oklahoma Statutes. The Commissioner's order may require a person found to be in violation of the Viatical Settlements Act of 2008 to make restitution to persons aggrieved by violations of the Viatical Settlements Act of 2008.

F. A person convicted of a violation of the Viatical Settlements Act by a court of competent jurisdiction shall be guilty of a felony punishable as follows:

1. To imprisonment for not more than twenty (20) years or to payment of a fine of not more than One Hundred Thousand Dollars (\$100,000.00), or both, if the value of the viatical settlement contract is more than Thirty-five Thousand Dollars (\$35,000.00);

2. To imprisonment for not more than ten (10) years or to payment of a fine of not more than Twenty Thousand Dollars (\$20,000.00), or both, if the value of the viatical settlement contract is more than Two Thousand Five Hundred Dollars (\$2,500.00) but not more than Thirty-five Thousand Dollars (\$35,000.00);

3. To imprisonment for not more than five (5) years or to payment of a fine of not more than Ten Thousand Dollars (\$10,000.00), or both, if the value of the viatical settlement contract is more than Five Hundred Dollars (\$500.00) but not more than Two Thousand Five Hundred Dollars (\$2,500.00); or

4. To imprisonment for not more than one (1) year or to payment of a fine of not more than Three Thousand Dollars (\$3,000.00), or both, if the value of the viatical settlement contract is Five Hundred Dollars (\$500.00) or less.

A person convicted of a violation of the Viatical Settlements Act of 2008 shall be ordered to pay restitution to persons aggrieved by the violation of the Viatical Settlements Act of 2008. Restitution shall be ordered in addition to a fine or imprisonment, but not in lieu of a fine or imprisonment.

G. Except for a fraudulent viatical settlement act committed by a viator, the enforcement provisions and penalties of this section shall not apply to a viator. A person convicted of a violation of the Viatical Settlements Act of 2008 by a court of competent jurisdiction may be sentenced in accordance with paragraph 1, 2, 3 or 4 of subsection F of this section based on the greater of (i) the value of property, services, or other benefit wrongfully obtained or attempted to obtain, or (ii) the aggregate economic loss suffered by any person as a result of the violation. A person convicted of a fraudulent viatical settlement act must be ordered to pay restitution to persons aggrieved by the fraudulent viatical settlement act. Restitution must be ordered in addition to a fine or imprisonment but not in lieu of a fine or imprisonment.

In any prosecution under paragraphs 1, 2, 3 and 4 of subsection F of this section the value of the viatical settlement contracts within any six-month period may be aggregated and the defendant charged accordingly in applying the provisions of this section. When two or more offenses are committed by the same person in two or more counties, the accused may be prosecuted in any county in which one of the offenses was committed for all of the offenses aggregated under this section. The applicable statute of limitations provision under Section 93 of Title 12 of the Oklahoma Statutes shall not begin to run until the insurance company or law enforcement agency is aware of the fraud, but in no event may the prosecution be commenced later than seven (7) years after the act has occurred. Added by Laws 2008, c. 183, § 14, eff. Nov. 1, 2008. Amended by Laws 2008, c. 344, § 9, eff. Nov. 1, 2008.

§36-4055.15. Violation of act - Deceptive trade practice.

A violation of the Viatical Settlements Act of 2008, including the commission of a fraudulent viatical settlement act, shall be considered a deceptive trade practice under Sections 1201 through 1219 of Title 36 of the Oklahoma Statutes subject to the penalties contained in those sections.

Added by Laws 2008, c. 183, § 15, eff. Nov. 1, 2008.

§36-4055.16. Authority of Commissioner.

The Insurance Commissioner shall have the authority to:

1. Promulgate regulations implementing the Viatical Settlements Act of 2008;

2. Establish standards for evaluating reasonableness of payments under viatical settlement contracts for persons who are terminally or chronically ill. This authority includes, but is not limited to, regulation of discount rates used to determine the amount paid in exchange for assignment, transfer, sale, devise or bequest of a benefit under a life insurance policy insuring the life of a person that is chronically or terminally ill;

3. Establish appropriate licensing requirements, fees and standards for continued licensure for viatical settlement providers and brokers;

4. Require a bond or other mechanism for financial accountability for viatical settlement providers and brokers; and

5. Adopt rules governing the relationship and responsibilities of both insurers and viatical settlement providers and viatical settlement brokers during the viatication of a life insurance policy or certificate.

Added by Laws 2008, c. 183, § 16, eff. Nov. 1, 2008.

§36-4055.17. Compliance with act.

A. A viatical or life settlement provider lawfully transacting business in this state prior to the effective date of the Viatical Settlements Act of 2008 may continue to do so pending approval or disapproval of that person's application for a license if the application is filed with the Commissioner not later than sixty (60) calendar days after publication of the application form and instructions for licensure of providers. If the publication of the application form and instructions is prior to the effective date of this act, then the application shall be filed no later than sixty (60) calendar days after the effective date of the act. During the time that such an application is pending with the Commissioner, the applicant may use any form of viatical settlement contract that has been filed with the Commissioner pending approval thereof, provided that such form is otherwise in compliance with the provisions of this act. Any person transacting business in this state under this subsection shall comply with all other requirements of this act.

B. A person who has lawfully negotiated viatical or life settlement contracts between any owner residing in this state and one or more providers for at least one year immediately prior to the effective date of this act may continue to do so pending approval or disapproval of that person's application for a license if the application is filed with the Commissioner not later than sixty (60) calendar days after publication of the application form and instructions for licensure of brokers. If the publication of the application form and instructions is prior to the effective date of this act, then the application shall be filed no later than sixty

(60) calendar days after the effective date of the act. Any person transacting business in this state under this subsection shall comply with all other requirements of this act.

Added by Laws 2008, c. 183, § 17, eff. Nov. 1, 2008. Amended by Laws 2008, c. 344, § 10, eff. Nov. 1, 2008.

§36-4061. Definitions - Reserves and related actuarial items - Appropriate computation and adequacy - Periodic opinion and memorandum of qualified actuary - Requirements - Liability - Actuarial Opinion of Reserves - Confidentiality.

A. Definitions. For the purposes of this section, the following definitions shall apply on or after the operative date of the valuation manual:

1. "Accident and health insurance" means contracts that incorporate morbidity risk and provide protection against economic loss resulting from accident, sickness, or medical conditions and as may be specified in the valuation manual;

2. "Appointed actuary" means a qualified actuary who is appointed in accordance with the valuation manual to prepare the actuarial opinion required in this section;

3. "Company" means an entity which:

a. has written, issued, or reinsured life insurance contracts, accident and health insurance contracts, or deposit-type contracts in this state and has at least one such policy in force or on claim, or

b. has written, issued, or reinsured life insurance contracts, accident and health insurance contracts, or deposit-type contracts in any state and is required to hold a certificate of authority to write life insurance, accident and health insurance, or deposit-type contracts in this state;

4. "Deposit-type contract" means contracts that do not incorporate mortality or morbidity risks and as may be specified in the valuation manual;

5. "Life insurance" means contracts that incorporate mortality risk, including annuity and pure endowment contracts, and as may be specified in the valuation manual;

6. "NAIC" means the National Association of Insurance Commissioners;

7. "Principle-based valuation" means a reserve valuation that uses one or more methods or one or more assumptions determined by the insurer and is required to comply with subsection Q of Section 1510 of this title as specified in the valuation manual;

8. "Qualified actuary" means an individual who is qualified to sign the applicable statement of actuarial opinion in accordance with the American Academy of Actuaries qualification standards for

actuaries signing such statements and who meets the requirements specified in the valuation manual; and

9. "Valuation manual" means the manual of valuation instructions adopted by the NAIC as specified in Section 1510 of this title or as subsequently amended.

B. Actuarial Opinion Beginning January 1, 1998, and Prior to the Operative Date of the Valuation Manual.

1. Every life insurance company doing business in this state shall annually, and quarterly if required by the Insurance Commissioner, submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the Insurance Commissioner by rule are computed appropriately, are based on assumptions which satisfy contractual provisions, are consistent with prior reported accounts and comply with applicable laws of this state. The Commissioner by rule shall define the specifics of this opinion and add any other items deemed to be necessary to its scope.

2. a. Every life insurance company, except as exempted by or pursuant to rule, shall also annually, and quarterly if required by the Insurance Commissioner, include in the opinion required by paragraph 1 of this subsection, an opinion of the same qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the Commissioner by rule, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including but not limited to the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including but not limited to the benefits under and expenses associated with the policies and contracts.

b. The Commissioner may provide by rule for a transition period for establishing any higher reserves which the qualified actuary may deem necessary in order to render the opinion required by this section.

3. Each opinion required by paragraph 2 of this subsection shall be accompanied by a memorandum, in form and substance acceptable to the Commissioner as specified by rule, prepared to support each actuarial opinion. If the insurance company fails to provide a supporting memorandum at the request of the Commissioner within a period specified by rule, or the Commissioner determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by the rules or is otherwise unacceptable to the Commissioner, the Commissioner may engage a

qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare such supporting memorandum as is required by the Commissioner.

4. Every opinion shall be governed by the following provisions:
 - a. the opinion shall be submitted with the annual statement and quarterly statement, if a quarterly statement is required by the Commissioner, reflecting the valuation of such reserve liabilities for each year,
 - b. the opinion shall apply to all business in force including individual and group health insurance plans, in form and substance acceptable to the Commissioner as specified by rule,
 - c. the opinion shall be based on standards adopted from time to time by the Actuarial Standards Board and on such additional standards as the Commissioner may by rule prescribe,
 - d. in the case of an opinion required to be submitted by a foreign or alien company, the Commissioner may accept the opinion filed by that company with the insurance supervisory official of another state if the Commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this state,
 - e. except in cases of fraud or willful misconduct, the qualified actuary shall not be liable for damages to any person, other than the insurance company and the Commissioner, for any act, error, omission, decision or conduct with respect to the actuary's opinion, and
 - f. disciplinary action by the Commissioner against the company or the qualified actuary shall be defined in rules by the Commissioner.
5. a. Any memorandum in support of the opinion, and any other material provided by the company to the Commissioner in connection therewith, shall be kept confidential by the Commissioner and shall not be made public and shall not be subject to subpoena, other than for the purpose of defending an action seeking damages from any person by reason of any action required by this section or by rules promulgated hereunder; provided, however, that the memorandum or other material may otherwise be released by the Commissioner as follows:
 - (1) with the written consent of the company, or
 - (2) to the American Academy of Actuaries upon request stating that the memorandum or other material is required for the purpose of professional

disciplinary proceedings and setting forth procedures satisfactory to the Commissioner for preserving the confidentiality of the memorandum or other material.

- b. Once any portion of the confidential memorandum is cited by the company in its marketing or is cited before any governmental agency other than a state insurance department or is released by the company to the news media, all portions of the confidential memorandum shall be no longer confidential.

6. For the purposes of this section, "qualified actuary" means a member in good standing of the American Academy of Actuaries who meets the requirements set forth in rules promulgated by the Insurance Commissioner.

C. Actuarial Opinion of Reserves after the Operative Date of the Valuation Manual.

1. Every company with outstanding life insurance contracts, accident and health insurance contracts or deposit-type contracts in this state and subject to regulation by the commissioner shall annually, and quarterly if required by the Insurance Commissioner, submit the opinion of the appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts are computed appropriately, are based on assumptions which satisfy contractual provisions, are consistent with prior reported accounts and comply with applicable laws of this state. The valuation manual will prescribe the specifics of this opinion including any items deemed to be necessary to its scope.

2. Every life insurance company with outstanding life insurance contracts, accident health insurance contracts or deposit type contracts in this state and subject to regulation by the commissioner, except as exempted in the valuation manual, shall also annually, and quarterly if required by the Insurance Commissioner, include in the opinion required by paragraph 1 of this subsection, an opinion of the same appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified in the valuation manual, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including, but not limited to, the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including, but not limited to, the benefits under and expenses associated with the policies and contracts.

3. Each opinion required by paragraph 2 of this subsection shall be accompanied by a memorandum, in form and substance as specified in the valuation manual, and acceptable to the Commissioner, prepared to support each actuarial opinion. If the

insurance company fails to provide a supporting memorandum at the request of the Commissioner within a period specified in the valuation manual or is otherwise unacceptable to the Commissioner, the Commissioner may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare such supporting memorandum as is required by the Commissioner.

4. Every opinion shall be governed by the following provisions:
 - a. the opinion shall be in form and substance as specified in the valuation manual and acceptable to the Commissioner,
 - b. the opinion shall be submitted with the annual statement and quarterly statement, if a quarterly statement is required by the Commissioner, reflecting the valuation of such reserve liabilities for each year ending on or after the operative date of the valuation manual,
 - c. the opinion shall apply to all policies and contracts subject to paragraph 2 of this subsection, plus other actuarial liabilities as may be specified in the valuation manual,
 - d. the opinion shall be based on standards adopted from time to time by the Actuarial Standards Board or its successor, and on such additional standards as may be prescribed in the valuation manual,
 - e. in the case of an opinion required to be submitted by a foreign or alien company, the Commissioner may accept the opinion filed by that company with the insurance supervisory official of another state if the Commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this state,
 - f. except in cases of fraud or willful misconduct, the appointed actuary shall not be liable for damages to any person, other than the insurance company and the Commissioner, for any act, error, omission, decision or conduct with respect to the appointed actuary's opinion, and
 - g. disciplinary action by the Commissioner against the company or the appointed actuary shall be defined in rules by the Commissioner.

D. Confidentiality.

1. For purposes of this subsection "confidential information" means:

- a. a memorandum in support of an opinion submitted under this section and any other documents, materials and other information, including, but not limited to, all

- working papers, and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in connection with such memorandum,
- b. all documents, materials and other information, including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in the course of an examination made under paragraph 6 of subsection P of Section 1510 of this title; provided, however, that if an examination report or other material prepared in connection with an examination made under Sections 309.1 through 309.7 of this title is not held as private and confidential information under Sections 309.1 through 309.7 of this title, an examination report or other material prepared in connection with an examination made under paragraph 6 of subsection P of Section 1510 of this title shall not be "Confidential Information" to the same extent as if such examination report or other material had been prepared under Sections 309.1 through 309.7 of this title,
 - c. any reports, documents, materials and other information developed by a company in support of, or in connection with, an annual certification by the company under subparagraph (b) of paragraph 2 of subsection Q of Section 1510 of this title evaluating the effectiveness of the company's internal controls with respect to a principle-based valuation and any other documents, materials and other information, including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in connection with such reports, documents, materials and other information,
 - d. any principle-based valuation report developed under subparagraph (c) of paragraph 2 of subsection Q of Section 1510 of this title and any other documents, materials and other information, including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in connection with such report, and
 - e. any documents, materials, data and other information submitted by a company under subsection R of Section 1510 of this title, collectively, "experience data", and any other documents, materials, data and other information, including, but not limited to, all

working papers, and copies thereof, created or produced in connection with such experience data, in each case that include any potentially company-identifying or personally identifiable information, that is provided to or obtained by the commissioner, together with any "experience data", the "experience materials", and any other documents, materials, data and other information, including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in connection with such experience materials.

2. Privilege for, and Confidentiality of, Confidential Information.

- a. except as provided in this subsection, a company's Confidential Information is confidential by law and privileged, and shall not be subject to Oklahoma Open Records Act, shall not be subject to subpoena and shall not be subject to discovery or admissible in evidence in any private civil action; provided, however, that the commissioner is authorized to use the Confidential Information in the furtherance of any regulatory or legal action brought against the company as a part of the commissioner's official duties,
- b. neither the commissioner nor any person who received Confidential Information while acting under the authority of the commissioner shall be permitted or required to testify in any private civil action concerning any Confidential Information,
- c. in order to assist in the performance of the commissioner's duties, the commissioner may share Confidential Information:
 - (1) with other state, federal and international regulatory agencies and with the NAIC and its affiliates and subsidiaries,
 - (2) in the case of Confidential Information specified in subparagraphs (a) and (d) of paragraph 1 of this subsection, with the Actuarial Board for Counseling and Discipline or its successor upon request stating that the Confidential Information is required for the purpose of professional disciplinary proceedings and with state, federal and international law enforcement officials, and
 - (3) in the case of (1) and (2), provided that such recipient agrees, and has the legal authority to agree, to maintain the confidentiality and privileged status of such documents, materials,

data and other information in the same manner and to the same extent as required for the commissioner.

- d. the commissioner may receive documents, materials, data and other information, including otherwise confidential and privileged documents, materials, data or information, from the NAIC and its affiliates and subsidiaries, from regulatory or law enforcement officials of other foreign or domestic jurisdictions and from the Actuarial Board for Counseling and Discipline or its successor and shall maintain as confidential or privileged any document, material, data or other information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or other information,
- e. the commissioner may enter into agreements governing sharing and use of information consistent with paragraph 2 of this subsection,
- f. no waiver of any applicable privilege or claim of confidentiality in the Confidential Information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in subparagraph (c) of paragraph 2 of this subsection,
- g. a privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under paragraph 2 of this subsection shall be available and enforced in any proceeding in, and in any court of, this state,
- h. in this subsection "regulatory agency", "law enforcement agency" and the "NAIC" include, but are not limited to, their employees, agents, consultants and contractors.

3. Notwithstanding paragraph 2 of this subsection, any Confidential Information specified in subparagraphs a and d of paragraph 1 of this subsection:

- a. may be subject to subpoena for the purpose of defending an action seeking damages from the appointed actuary submitting the related memorandum in support of an opinion submitted under this section or principle-based valuation report developed under subparagraph c of paragraph 2 of subsection Q of Section 1510 of this title by reason of an action required by Section 1510 of this title or by rules promulgated hereunder,

- b. may otherwise be released by the commissioner with the written consent of the company, and
- c. once any portion of a memorandum in support of an opinion submitted under this section or a principle-based valuation report developed under subparagraph c of paragraph 2 of subsection Q of Section 1510 of this title is cited by the company in its marketing or is publicly volunteered to or before a governmental agency other than a state insurance department or is released by the company to the news media, all portions of such memorandum or report shall no longer be confidential.

Added by Laws 1997, c. 273, § 4, eff. July 1, 1997. Amended by Laws 2001, c. 363, § 20, eff. July 1, 2001; Laws 2014, c. 50, § 2, eff. Nov. 1, 2014.

§36-4071. Short title.

This act shall be known and may be cited as the "Oklahoma Charitable Gift Annuity Act".

Added by Laws 1998, c. 141, § 1, emerg. eff. April 21, 1998.

§36-4072. Definitions.

As used in this act:

1. "Charitable gift annuity" means a transfer of cash or other property by a donor or donors to a charitable organization in return for periodic payments by the charitable organization commencing on the date of the agreement or in the future to one or more persons designated by the donor or donors over the lives of such persons;

2. "Qualified charitable gift annuity" means a charitable gift annuity which:

- a. has an actuarial value using the actuarial factors and interest rate established by the Internal Revenue Code to determine charitable deductions for federal tax purposes which is less than ninety percent (90%) of the value of the cash or other property transferred by the donor or donors to the charitable organization and the difference in value constitutes a charitable deduction for federal tax purposes,
- b. has periodic payments that are calculated using a rate which will reasonably assure the promised payments to the annuitant on the date the annuity is issued, and
- c. is described in Section 501(m)(5) of the Internal Revenue Code;

3. "Charitable organization" means an entity that:

- a. is described by Sections 501(c)(3) and 170(c) of the Internal Revenue Code, and
- b. is qualified to do business in this state;

4. "Qualified charitable organization" means a charitable organization that, on the date it issues its first qualified charitable gift annuity contract:

- a. has a minimum of One Hundred Thousand Dollars (\$100,000.00) in unrestricted assets that are exclusive of the assets comprising its qualified charitable gift annuities, and
- b. has been in continuous operation for at least three (3) years or is a successor or affiliate of a charitable organization that has been in continuous operation for at least three (3) years; and

5. "Internal Revenue Code" means the Internal Revenue Code of 1986 (26 U.S.C.), as amended, or any similar successor federal tax legislation.

Added by Laws 1998, c. 141, § 2, emerg. eff. April 21, 1998.

§36-4073. Transaction of insurance business.

The issuance of a qualified charitable gift annuity by a qualified charitable organization shall not constitute transacting a business of insurance in this state.

Added by Laws 1998, c. 141, § 3, emerg. eff. April 21, 1998.

§36-4074. Notification to Insurance Commissioner.

On or before ninety (90) days after the later of the effective date of this act or the date on which it issues its first charitable gift annuity contract, the charitable organization shall notify the Insurance Commissioner in writing that it has issued one or more charitable gift annuities. This notice shall be signed by an officer or director of the charitable organization and shall:

- a. show the name and principal address of the charitable organization,
- b. certify that the organization is an organization described by Section 501(c)(3) of the Internal Revenue Code and Section 170(c) of the Internal Revenue Code,
- c. have attached a copy of the organization's letter from the Internal Revenue Service declaring its exempt status,
- d. certify that the charitable organization has issued one or more charitable gift annuity contracts and that these charitable gift annuity contracts are qualified charitable gift annuity contracts as defined in this act,
- e. certify that the charitable organization has a minimum of One Hundred Thousand Dollars (\$100,000.00) in unrestricted assets exclusive of the assets comprising the qualified charitable gift annuities issued by the charitable organization,

- f. certify that the charitable organization has been in continuous operation for at least three (3) years or is a successor or an affiliate of a charitable organization that has been in continuous operation for at least three (3) years, and
- g. have attached the most recent annual audit of the charitable organization prepared by an independent certified public accountant or accounting firm or individual holding a permit to practice public accounting in accordance with generally accepted accounting principles.

Added by Laws 1998, c. 141, § 4, emerg. eff. April 21, 1998.

Amended by Laws 1998, c. 406, § 2, eff. July 1, 1998.

§36-4075. Statement of nonregulation.

In its promotional literature, applications and agreements for qualified charitable gift annuities, the qualified charitable organization shall insert the following separate paragraph in print no smaller than that employed in the document generally:

"A charitable gift annuity is not regulated by the Oklahoma Insurance Department and is not protected by a guaranty association affiliated with the Oklahoma Insurance Department."

Added by Laws 1998, c. 141, § 5, emerg. eff. April 21, 1998.

§36-4076. Financial statement.

Each qualified charitable organization issuing qualified charitable gift annuities shall provide the Insurance Commissioner with a copy of its annual audited financial statement prepared by an independent certified public accountant or accounting firm or individual holding a permit to practice public accounting in accordance with generally accepted accounting principles within ninety (90) days of receipt of the final audit report by the qualified charitable organization.

Added by Laws 1998, c. 141, § 6, emerg. eff. April 21, 1998.

§36-4077. Information required to be submitted to Insurance Commissioner.

Except as otherwise required by this act, a qualified charitable organization shall not be required to submit information to the Insurance Commissioner except as necessary to determine any penalties pursuant to Section 10 of this act.

Added by Laws 1998, c. 141, § 7, emerg. eff. April 21, 1998.

§36-4078. Applicability of Oklahoma Open Records Act and Oklahoma Open Meeting Act.

Nothing herein shall be construed to subject a charitable organization to the Oklahoma Open Records Act or the Oklahoma Open

Meeting Act; provided, however, that the notices required by Section 4 of this act and the audited financial statements required by Section 6 of this act which are in the possession of the Oklahoma Insurance Department shall be deemed a "record" as defined in the Oklahoma Open Records Act.

Added by Laws 1998, c. 141, § 8, emerg. eff. April 21, 1998.

§36-4079. Purchase of annuities authorized.

A qualified charitable organization may use a portion of the money or property received in exchange for a qualified charitable gift annuity to purchase an annuity upon the life of the annuitant of the qualified charitable gift annuity from an insurance company qualified to transact a business of insurance in this state.

Added by Laws 1998, c. 141, § 9, emerg. eff. April 21, 1998.

§36-4080. Enforcement of compliance.

A. If the Insurance Commissioner or an independent hearing examiner finds that a violation of this act has occurred, the Insurance Commissioner shall enforce compliance with this act by sending a letter by certified mail, return receipt requested, demanding that the charitable organization comply with this act. If the charitable organization fails to comply with the demand within thirty (30) days of receipt of the letter, the charitable organization may be censured by the Insurance Commissioner or may be subject to a civil fine of not less than One Thousand Dollars (\$1,000.00) but not more than Ten Thousand Dollars (\$10,000.00) until such time as the charitable organization brings itself into compliance with this act.

B. If the Insurance Commissioner or an independent hearing examiner finds that the violation or threatened violation of this act is willful and is substantially injurious to the public, the Commissioner may file an action in district court to prevent, restrain or enjoin such violation or threatened violation.

C. The failure of a charitable organization to comply with the requirements of this act does not prevent a charitable gift annuity from otherwise being a charitable gift annuity under the Internal Revenue Code.

Added by Laws 1998, c. 141, § 10, emerg. eff. April 21, 1998.

§36-4081. Annuities issued before effective date of act.

A charitable gift annuity issued before the effective date of this act which does not meet the definition of a qualified charitable gift annuity under this act shall be deemed to be a qualified charitable gift annuity under this act.

Added by Laws 1998, c. 141, § 11, emerg. eff. April 21, 1998.

§36-4082. Issuance of annuities not to constitute certain agreements, contracts or combinations.

The issuance of a qualified charitable gift annuity by a qualified charitable organization is not an act, agreement, contract, or combination in the form of trust, or otherwise, or conspiracy in restraint of trade or commerce within this state. Added by Laws 1998, c. 141, § 12, emerg. eff. April 21, 1998.

§36-4085. Repealed by Laws 2008, c. 183, § 20, eff. Nov. 1, 2008.

§36-4086. Repealed by Laws 2008, c. 183, § 20, eff. Nov. 1, 2008.

§36-4087. Repealed by Laws 2008, c. 183, § 20, eff. Nov. 1, 2008.

§36-4088. Repealed by Laws 2008, c. 183, § 20, eff. Nov. 1, 2008.

§36-4089. Repealed by Laws 2008, c. 183, § 20, eff. Nov. 1, 2008.

§36-4090. Repealed by Laws 2008, c. 183, § 20, eff. Nov. 1, 2008.

§36-4091. Repealed by Laws 2008, c. 183, § 20, eff. Nov. 1, 2008.

§36-4091.1. Repealed by Laws 2008, c. 183, § 20, eff. Nov. 1, 2008.

§36-4092. Repealed by Laws 2008, c. 183, § 20, eff. Nov. 1, 2008.

§36-4093. Repealed by Laws 2008, c. 183, § 20, eff. Nov. 1, 2008.

§36-4094. Repealed by Laws 2008, c. 183, § 20, eff. Nov. 1, 2008.

§36-4095. Repealed by Laws 2008, c. 183, § 20, eff. Nov. 1, 2008.

§36-4095.1. Repealed by Laws 2008, c. 183, § 20, eff. Nov. 1, 2008.

§36-4095.2. Repealed by Laws 2008, c. 183, § 20, eff. Nov. 1, 2008.

§36-4096. Repealed by Laws 2008, c. 183, § 20, eff. Nov. 1, 2008.

§36-4101. Classes of policies permitted - Eligibility - Premiums - Number insured - Amount of insurance.

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

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

- a. The employees eligible for insurance under the policy shall be all of the employees of the employer, or all of any class or classes thereof determined by conditions pertaining to their employment. The policy may provide that the term "employees" shall include the employees of one or more subsidiary corporations, and the employees, individual proprietors and partners of one or more affiliated corporations, proprietors or partnerships if the business of the employer and of such affiliated corporations, proprietors or partnerships is under common control through stock ownership or contract, or otherwise. The policy may provide that the term "employees" shall include the individual proprietor or partners if the employer is an individual proprietor or a partnership. The policy may provide that the term "employees" shall include retired employees. No director of a corporate employer shall be eligible for insurance under the policy unless such a person is otherwise eligible as a bona fide employee of the corporation by performing services other than the usual duties of a director. No individual proprietor or partner shall be eligible for insurance under the policy unless he is actively engaged in and devotes a substantial part of his time to the conduct of the business of the proprietor or partnership. The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship. A policy issued to insure the employees of a public body may provide that the term "employee" shall include elected or appointed officials.
- b. The premium for the policy shall be paid by the policyholder, either wholly from the employer's funds or funds contributed by him, or partly from such funds and partly from funds contributed by the insured employees, or from funds contributed wholly by the insured employees. A policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees, or all except any as to whom evidence of insurability is not satisfactory to the insurer.
- c. The amounts of insurance under the policy must be based upon some plan precluding individual selection either by the employees or by the employer or trustee;

2. A policy issued to a creditor, who shall be deemed to be the policyholder, to insure debtors of the creditor. Credit unions and

associations formed for the purpose of making loans to their members shall be deemed to be creditors within the meaning of this section. Policies issued to a creditor to insure debtors of the creditor are subject to the following requirements:

- a. The debtors eligible for insurance under the policy shall be all of the debtors of the creditor or all of any class or classes thereof determined by conditions pertaining to the indebtedness or to the purchase giving rise to the indebtedness. The policy may provide that the term "debtors" shall include the debtors of one or more subsidiary corporations, and the debtors of one or more affiliated corporations, proprietors or partnerships if the business of the policyholder and of such affiliated corporations, proprietors or partnerships is under common control through stock ownership, contract or otherwise.
- b. The premium for the policy shall be paid by the policyholder, either from the creditor's funds, or from charges collected from the insured debtors, or from both. A policy on which part or all of the premium is to be derived from the collection from the insured debtors of identifiable charges not required of uninsured debtors shall not include, in the class or classes of debtors eligible for insurance, debtors under obligation outstanding at its date of issue without evidence of individual insurability unless at least seventy-five percent (75%) of the then eligible debtors elect to pay the required charges. A policy on which no part of the premium is to be derived from the collection of such identifiable charges must insure all eligible debtors, or all except any as to whom evidence of individual insurability is not satisfactory to the insurer.
- c. The policy may be issued only if the group of eligible debtors is then receiving new entrants at the rate of at least one hundred persons yearly, or may reasonably be expected to receive at least one hundred new entrants during the first policy year, and only if the policy reserves to the insurer the right to require evidence of individual insurability if less than seventy-five percent (75%) of the new entrants become insured.
- d. The amount of insurance on the life of any debtor shall at no time exceed the amount owed by him which is repayable to the creditor, or One Hundred Thousand Dollars (\$100,000.00), whichever is less, provided further, no company licensed to do business in this

state shall issue in excess of One Hundred Thousand Dollars (\$100,000.00) group credit life insurance on one individual in the State of Oklahoma.

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

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

- a. The members eligible for insurance under the policy shall be all of the members of the union, or all of any class or classes thereof determined by conditions pertaining to their employment, or to membership in the union, or both.
- b. The premium for the policy shall be paid by the policyholder, either wholly from the union's funds, or partly from such funds and partly from funds contributed by the insured members specifically for their insurance, or from funds contributed wholly by the insured members. A policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members or all except any as to whom evidence of individual insurability is not satisfactory to the insurer.
- c. The amount of insurance under the policy must be based upon some plan precluding individual selection either by the members or by the union;

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

- a. The persons eligible for insurance shall be all of the employees of the employers or all of the members of the union, or all the members of an association of persons, licensed by the State of Oklahoma to engage in a recognized profession, or all of any class or classes thereof determined by conditions pertaining to their employment, or to membership in the unions, or to both, or pertaining to membership in the association of persons, licensed by the State of Oklahoma to engage in a recognized profession. The policy may provide that the term "employees" shall include the individual proprietor or partners if any employer is an individual proprietor or a partnership. The policy may provide that the term "employees" shall include retired employees. No director of a corporate employer shall be eligible for insurance under the policy unless such person is otherwise eligible as a bona fide employee of the corporation by performing services other than the usual duties of a director. No individual proprietor or a partner shall be eligible for insurance under the policy unless he is actively engaged in and devotes a substantial part of his time to the conduct of the business of the proprietor or partnership. The policy may provide that the term "employees" shall include the trustees or their employees, or both if their duties are principally connected with such trusteeship, and that the term "members of an association" shall include employees of members.
- b. The premium for the policy shall be paid by the trustees wholly from funds contributed by the employer or employers of the insured persons, or by the union or unions, or by both, or by an association of persons, licensed by the State of Oklahoma to engage in a recognized profession, or from funds contributed wholly or in part by the insured persons. A policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance must insure all eligible persons, or all except any as to whom evidence of individual insurability is not satisfactory to the insurer.
- c. The policy must cover at date of issue at least one hundred persons; and if the fund is established by the members of an association of employers the policy may be issued only if (a) either (i) the participating employers constitute at date of issue at least sixty percent (60%) of those employer members whose

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

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

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

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

- a. The members eligible for insurance under the policy shall be all the members of the credit union or all of any class or classes thereof.
- b. The premiums for the policy shall be paid by the policyholder, either wholly from the credit union's funds, or partly from such funds and partly from funds contributed by the insured members specifically for their insurance. A policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members or all except any as to whom evidence of individual insurability is not satisfactory to the insurer.
- c. The amount of insurance under the policy may be based on the amount of the member's savings in the credit union or upon some other plan precluding individual selection either by the members or by the credit union;

7. A policy issued to a charitable, benevolent, educational or religious institution, or their agencies, to insure the members

thereof for the purpose set forth in subsection D of Section 3604 of this title;

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

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

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

- a. has been actively in existence for at least five (5) years,
- b. has been formed and maintained in good faith for purposes other than obtaining insurance,
- c. does not condition membership in the association on any health status-related factor relating to an individual, including an employee of an employer or a dependent of an employee or association member,
- d. makes life insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such member or individuals eligible for coverage through a member,
- e. does not make life insurance coverage offered through the association available other than in connection with a member of the association, and
- f. meets such additional requirements as may be imposed under state law;

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

- a. no such group life insurance policy shall be delivered in this state unless the Commissioner of Insurance finds that:
 - (1) the issuance of such group policy is not contrary to the best interest of the public,
 - (2) the issuance of the group policy would result in economies of acquisition or administration, and
 - (3) the benefits are reasonable in relation to the premiums charged, and
- b. the premium for the policy shall be paid either from the policyholder's funds or from funds contributed by the covered person or from both; or

11. A policy issued to cover any other substantially similar group which, in the discretion of the Insurance Commissioner, may be subject to the issuance of a group life policy or contract. Added by Laws 1957, p. 378, § 4101, operative July 1, 1957. Amended by Laws 1961, p. 274, § 1, emerg. eff. June 28, 1961; Laws 1968, c. 94, § 1, emerg. eff. April 1, 1968; Laws 1974, c. 92, § 1, emerg. eff. April 24, 1974; Laws 1975, c. 82, § 1, emerg. eff. April 25, 1975; Laws 1980, c. 23, § 1, emerg. eff. March 24, 1980; Laws 1982, c. 146, § 1, operative Oct. 1, 1982; Laws 1991, c. 223, § 2, emerg. eff. May 23, 1991; Laws 2000, c. 353, § 42, eff. Nov. 1, 2000; Laws 2005, c. 129, § 15, eff. Nov. 1, 2005; Laws 2007, c. 125, § 20, eff. July 1, 2007.

§36-4101.1. Extension of policies to insure dependents - Payment of premiums - Conversion rights.

A. Insurance under any group life insurance policy issued pursuant to paragraphs 1, 3, 4, 5 and 6 of Section 4101 of this title, may be extended to insure the dependents, or any class or classes thereof, of each insured employee or member who so elects in amounts in accordance with a plan which precludes individual selection. The term "dependent" means the spouse of the insured employee or member or an insured employee's or member's child under twenty-six (26) years of age or his or her child twenty-six (26) years or older who is attending an educational institution and relying upon the insured employee or member for financial support.

B. Premiums for the insurance on such dependents shall be paid by the policyholder either wholly from policyholder's funds, or from funds contributed wholly by the employees or members, or partly from funds contributed by the policyholder and partly by the employees or members.

C. A dependent pursuant to this section shall have the same conversion right as to the insurance on his or her life as is vested in the employee or union member.

D. Notwithstanding the provisions of paragraph 7 of Section 4103 of this title, only one certificate need be issued for each family unit if a statement concerning any dependent's coverage is included in such certificate.

Added by Laws 1969, c. 234, § 1, emerg. eff. April 21, 1969. Amended by Laws 1978, c. 162, § 5, eff. Oct. 1, 1978; Laws 1988, c. 29, § 1, eff. Nov. 1, 1988; Laws 1997, c. 418, § 95, eff. Nov. 1, 1997; Laws 2007, c. 125, § 21, eff. July 1, 2007; Laws 2016, c. 73, § 6, eff. Nov. 1, 2016; Laws 2017, c. 287, § 5, eff. Nov. 1, 2017.

§36-4103. Schedule of premium rates - Required provisions.

A. No policy of group life insurance shall be delivered in this state unless it contains in substance the following provisions, or provisions which are more favorable to the persons insured, or at

least as favorable to the persons insured and more favorable to the policyholder; provided, however, that:

1. Paragraphs 6 through 10 of this section shall not apply to policies issued to a creditor to insure debtors of such creditor;

2. That the standard provisions required for individual life insurance policies shall not apply to group life insurance policies; and

3. That if the group life insurance policy is on a plan of insurance other than the term plan, it shall contain a nonforfeiture provision or provisions which is or are equitable to the insured persons and to the policyholder, but nothing herein shall be construed to require that group life insurance policies contain the same nonforfeiture provisions as are required for individual life insurance policies:

B. A provision that the policyholder is entitled to a grace period of thirty-one (31) days for the payment of any premium due except the first, during which grace period the death benefit coverage shall continue in force, unless the policyholder shall have given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder shall be liable to the insurer for the payment of a pro rata premium for the time the policy was in force during such grace period.

C. A provision that the validity of the policy shall not be contested, except for nonpayment of premiums, after it has been in force for two (2) years from its date of issue, and that no statement made by any person insured under the policy relating to his or her insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two (2) years during such person's lifetime nor unless it is contained in a written instrument signed by him or her.

D. A provision that a copy of the application, if any, of the policyholder shall be attached to the policy when issued, that all statements made by the policyholder or by the persons insured shall be deemed representations and not warranties, and that no statement made by any person insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such person or to his or her beneficiary.

E. A provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of his or her coverage.

F. A provision specifying an equitable adjustment of premiums or of benefits or of both to be made in the event the age of a

person insured has been misstated, such provision to contain a clear statement of the method of adjustment to be used.

G. A provision that any sum becoming due by reason of the death of the person insured shall be payable to the beneficiary designated by the person insured, subject to the provisions of the policy in the event there is no designated beneficiary as to all or any part of such sum, living at the death of the person insured, and subject to any right reserved by the insurer in the policy and set forth in the certificate to pay at its option a part of such sum not exceeding Five Hundred Dollars (\$500.00) to any person appearing to the insurer to be equitably entitled thereto by reason of having incurred funeral or other expenses incident to the last illness or death of the person insured.

H. A provision that the insurer will issue to the policyholder for delivery to each person insured an individual certificate setting forth a statement as to the insurance protection to which he is entitled, to whom the insurance benefits are payable, and the rights and conditions set forth in paragraphs 8, 9 and 10 of this section.

I. A provision that if the insurance, or any portion of it, on a person covered under the policy ceases because of termination of employment or of membership in the class or classes eligible for coverage under the policy, such person shall be entitled to have issued to him or her by the insurer, without evidence of insurability, an individual policy of life insurance without disability or other supplementary benefits, provided an application for the individual policy shall be made, and the first premium paid to the insurer, within thirty-one (31) days after such termination, and provided further that:

- a. the individual policy shall, at the option of such person, be on any one of the forms, except term insurance, then customarily issued by the insurer at the age and for the amount applied for,
- b. the individual policy shall be in an amount not in excess of the amount of life insurance which ceases because of such termination, less, in the case of a person whose membership in the class or classes eligible for coverage terminates but who continues in employment in another class, the amount of any life insurance for which such person is or becomes eligible within thirty-one (31) days after such termination under any other group policy; provided that any amount of insurance which shall have matured on or before the date of such termination as an endowment payable to the person insured, whether in one sum or in installments or in the form of an annuity, shall not, for the purposes of this subparagraph, be included in

the amount which is considered to cease because of such termination, and

- c. the premium on the individual policy shall be at the insurer's then customary rate applicable to the form and amount of the individual policy, to the class of risk to which such person then belongs, and to his or her age attained on the effective date of the individual policy.

J. A provision that if the group policy terminates or is amended so as to terminate the insurance of any class of insured persons, every person insured thereunder at the date of such termination whose insurance terminates and who has been so insured for at least five (5) years prior to such termination date shall be entitled to have issued to him or her by the insurer an individual policy of life insurance, subject to the same conditions and limitations as are provided by paragraph 8 of this section, except that the group policy may provide that the amount of such individual policy shall not exceed the smaller of:

- a. the amount of the person's life insurance protection ceasing because of the termination or amendment of the group policy, less the amount of any life insurance for which he or she is or becomes eligible under any group policy issued or reinstated by the same or another insurer within thirty-one (31) days after such termination, and
- b. Ten Thousand Dollars (\$10,000.00).

K. A provision that if a person insured under the group policy dies during the period within which he or she would have been entitled to have an individual policy issued to him or her in accordance with paragraph I or J of this section and before such an individual policy shall have become effective, the amount of life insurance which he or she would have been entitled to have issued to him or her under such individual policy shall be payable as a claim under the group policy, whether or not application for the individual policy or the payment of the first premium therefor has been made.

L. In the case of a policy issued to a creditor to insure debtors of such creditor, a provision that the insurer will furnish to the policyholder for delivery to each debtor insured under the policy a form which shall contain a statement that the life of the debtor is insured under the policy and that any death benefit paid thereunder by reason of his or her death shall be applied to reduce or extinguish the indebtedness.

Added by Laws 1957, p. 382, § 4103. Amended by Laws 1992, c. 65, § 5, eff. Sept. 1, 1992; Laws 2021, c. 478, § 26, emerg. eff. May 12, 2021.

§36-4104. Right to individual policy; notice of right; time for exercising right.

If any individual insured under a group life insurance policy hereafter delivered in this state becomes entitled under the terms of such policy to have an individual policy of life insurance issued to him without evidence of insurability, subject to making of application and payment of the first premium within the period specified in such policy, and if such individual is not given notice of the existence of such right at least fifteen (15) days prior to the expiration date of such period, then, in such event the individual shall have an additional period within which to exercise such right, but nothing herein contained shall be construed to continue any insurance beyond the period provided in such policy. This additional period shall expire fifteen (15) days next after the individual is given such notice but in no event shall such additional period extend beyond sixty (60) days next after the expiration date of the period provided in such policy. Written notice presented to the individual or mailed by the policyholder to the last-known address of the individual or mailed by the insurer to the last-known address of the individual as furnished by the policyholder shall constitute notice for the purpose of this paragraph.

Laws 1957, p. 384, § 4104.

§36-4105. Group annuity contracts; standard provisions.

No group annuity contract shall be delivered or issued for delivery in this state and no certificate shall be used in connection therewith unless it contains in substance the provisions set forth in Sections 4106 to 4110, inclusive, of this article, to the extent that such provisions are applicable to such contract or to such certificate, as the case may be, or provisions which are more favorable to annuitants, or not less favorable to annuitants and more favorable to the policyholders.

Laws 1957, p. 384, § 4104.

§36-4106. Group annuity; grace period.

In group annuity contracts there shall be a provision that there shall be a period of grace, either of thirty (30) days or of one (1) month, within which any stipulated payment to be remitted by the holder to the insurer, falling due after one (1) year from date of issue, may be made, subject, at the option of the insurer, to an interest charge thereon at a rate to be specified in the contract, which shall not exceed six percent (6%) per annum for the number of days of grace elapsing before such payment.

Laws 1957, p. 384, § 4106.

§36-4107. Group annuity; entire contract.

In group annuity contracts there shall be a provision specifying the document or documents which shall constitute the entire contract between parties. The document or documents so specified shall be only (a) the contract, (b) the contract together with the application of the holder of which a copy is attached thereto, or (c) the contract together with the application of the holder of which a copy is attached thereto, and the individual applications of annuitants on file with the insurer and referred to therein. Laws 1957, p. 384, § 4104.

§36-4108. Group annuity; misstatements.

In group annuity contracts there shall be a provision, with an appropriate reference thereto in the certificate, for the equitable adjustment of the benefits payable under the contract or of the stipulated payments thereunder, if it be found that the sex, age, service, salary or any other fact determining the amount of any stipulated payment or the amount or date or dates of payment of any benefit with respect to any annuitant covered thereby has been misstated. Laws 1957, p. 385, § 4108.

§36-4109. Group annuity; nonforfeiture benefits.

In group annuity contracts there shall be a provision or provisions, with an appropriate reference thereto in the certificate, specifying the nature and basis of ascertainment of the benefits which will be available to an annuitant who contributes to the cost of the annuity and the conditions of payment thereof in the event of either the termination of employment of the annuitant, except by death, or the discontinuance of stipulated payments under the contract. Such provision or provisions shall, in either of such events, make available to an annuitant who contributes to the cost of the annuity a paid-up annuity payable commencing at a fixed date in an amount at least equal to that purchased by the contributions of the annuitant, determinable as of the respective dates of payment of the several contributions, as shown by a schedule in the contract for that purpose, based upon the same mortality table, rate of interest and loading formula used in computing the stipulated payments under such contract. Such provision or provisions may, by way of exception to the foregoing, provide that if the amount of the annuity determined as aforesaid from such fixed commencement date would be less than One Hundred Twenty Dollars (\$120.00) annually, the insurer may at its option, in lieu of granting such paid-up annuity, pay a cash surrender value at least equal to that hereinafter provided.

If cash surrender value, in lieu of such paid-up annuity, is allowed to the annuitant by the terms of such contract, it may be either in a single sum or in equal installments over a period of not

more than twelve (12) months and it shall at least equal either (a) or (b), whichever is less:

(a) The amount of reserve attributable to the annuitant's contributions less a surrender charge not exceeding thirty-five percent (35%) of the average annual contribution made by the annuitant; or

(b) The amount which would be payable as a death benefit at the date of surrender. Such contract shall also provide that in case of the death of an annuitant before the commencement date of the annuity, the insurer shall pay a death benefit at least equal to the aggregate amount of the annuitant's contributions without interest. If any benefits are available to the holder in either of such events, the contract shall contain a provision or provisions specifying the nature and basis of ascertainment of such benefits. Laws 1957, p. 385, § 4109.

§36-4110. Group annuity; certificates.

In group annuity contracts there shall be a provision that the insurer will issue to the holder of the contract for delivery to each annuitant who contributes thereunder an individual certificate setting forth a statement in substance of the benefits to which he is entitled under such contract.

Laws 1957, p. 385, § 4110.

§36-4111. "Employee life insurance" defined.

"Employee life insurance" is that plan of life insurance, other than salary savings life insurance or pension trust insurance and annuities, under which individual policies are issued to the employees of any employer and where such policies are issued on the lives of not less than five employees at date of issue. Premiums for such policies shall be paid by the employer or the trustee of a fund established by the employer either wholly from the employer's funds, or funds contributed by him, or partly from such funds and partly from funds contributed by the insured employees, or from funds contributed wholly by the insured employees.

Laws 1957, p. 385, § 4111.

§36-4112. Payment of proceeds - Time.

An insurer shall pay the proceeds of any benefits under group life insurance policy not more than thirty (30) days after the insurer has received proof of death of the insured. If the proceeds are not paid within this period, the insurer shall pay interest on the proceeds, at a rate which is not less than the current rate of interest on death proceeds on deposit with the insurer, from the date of death of the insured to the date when the proceeds are paid. Payment shall be deemed to have been made on the date an electronic payment is made or a check, draft or other valid instrument which is

equivalent to payment was placed in the U.S. mails in a properly addressed, postpaid envelope; or, if not so posted, on the date of delivery of such instrument to the beneficiary.

Added by Laws 1978, c. 162, § 4, eff. Oct. 1, 1978. Amended by Laws 1997, c. 418, § 96, eff. Nov. 1, 1997; Laws 2021, c. 478, § 27, emerg. eff. May 12, 2021.

§36-4201. Scope of article.

The provisions of this article apply only to industrial life insurance policies. Section 2 of this act (Return of policy within ten days), Section 3 of this act (Interest on proceeds), and Sections 4015 (Excluded or restricted coverage), 4024 (Limitation of liability), 4025 (Incontestability after reinstatement), 4028 (Dual or multiple pay policies prohibited), and 4029 (Nonforfeiture provisions; life insurance) of Article 40 (Life Insurance and Annuities) shall also apply to industrial life insurance.

Added by Laws 1957, p. 386, § 4201. Amended by Laws 1978, c. 162, § 6, eff. Oct. 1, 1978.

§36-4202. Industrial life insurance defined.

For the purposes of this article "Industrial Life Insurance" shall mean that form of life insurance where the face amount of the policy does not exceed One Thousand Dollars (\$1,000.00); and either

1. Under which the premiums are payable weekly, or

2. Under which the premiums are payable monthly or oftener, but less often than weekly; provided that in either case the words "Industrial Policy" are printed on the face of the policy as part of the descriptive matter thereof.

Laws 1957, p. 386, § 4202.

§36-4203. Required provisions.

No policy of industrial life insurance shall be delivered or be issued for delivery in this state unless it contains in substance the applicable provisions set forth in sections 4204 to 4216, inclusive, of this article.

Laws 1957, p. 386, § 4203.

§36-4204. Grace period.

There shall be a provision that the insured is entitled to a grace period of four (4) weeks within which the payment of any premiums after the first may be made, except that in policies the premiums for which are payable monthly, the period of grace shall be one (1) month, but not less than thirty (30) days, and that during the period of grace the policy shall continue in full force, but if during the grace period the policy becomes a claim, then any overdue and unpaid premiums may be deducted from any settlement under the policy.

Laws 1957, p. 386, § 4204.

§36-4205. Application and policy as entire contract; statements in application as representations.

There shall be a provision that the policy shall constitute the entire contract between the parties, or, if a copy of the application is endorsed upon or attached to the policy when issued, a provision that the policy and the application therefor shall constitute the entire contract. If the application is so made a part of the contract, the policy shall also provide that all statements made by the applicant in such application shall, in the absence of fraud, be deemed to be representations and not warranties.

Laws 1957, p. 386, § 4205.

§36-4206. Incontestability.

There shall be a provision that the policy (exclusive of provisions relating to disability benefits or to additional benefits in the event of death by accident or accidental means) shall be incontestable, except for nonpayment of premiums, after it has been in force during the lifetime of the insured for a period of two (2) years from its date of issue.

Laws 1957, p. 386, § 4206.

§36-4207. Misstatement of age.

There shall be a provision that if it is found that the age of the individual insured, or the age of any other individual considered in determining the premium, has been misstated, any amount payable or benefit accruing under the policy shall be such as the premium would have purchased at the correct age or ages.

Laws 1957, p. 386, § 4207.

§36-4208. Dividends.

If a participating policy, there shall be a provision that the insurer shall annually ascertain and apportion any divisible surplus accruing on the policy, except that at the option of the insurer such participation may be deferred to the end of the fifth policy year. This provision shall not prohibit the payment of additional dividends on default of payment of premiums or termination of the policy.

Laws 1957, p. 386, § 4208.

§36-4209. Nonforfeiture benefits.

There shall be provisions for nonforfeiture benefits and cash surrender values as required by Section 4029 of Article 40 (Life Insurance and Annuities).

Laws 1957, p. 386, § 4209.

§36-4210. Reinstatement.

There shall be a provision that unless the policy has been surrendered for its cash surrender value or unless the paid-up term insurance, if any, has expired, the policy will be reinstated at any time within two (2) years from the date of premium default upon written application therefor, the production of evidence of insurability satisfactory to the insurer, the payment of all premiums in arrears, and the payment or reinstatement of any other indebtedness to the insurer upon the policy, all with interest at a rate not exceeding six percent (6%) per annum compounded annually. Laws 1957, p. 386, § 4210.

§36-4211. Settlement.

There shall be a provision that when the policy becomes a claim by the death of the insured, settlement shall be made upon surrender of the policy and receipt of due proof of death. Laws 1957, p. 387, § 4211.

§36-4212. Authority to alter contract.

There shall be a provision that no agent shall have the power or authority to waive, change or alter any of the terms or conditions of any policy, except that at the option of the insurer the terms or conditions may be changed by an endorsement signed by a duly-authorized officer of the insurer. Laws 1957, p. 387, § 4212.

§36-4213. Beneficiary; change of beneficiary; payment of proceeds.

A. Each such policy shall have a space on the front or back page of the policy for the name of the beneficiary designated; and shall contain a reservation of the right to designate or change the beneficiary after the issuance of the policy.

B. The policy may also provide that no designation or change of beneficiary shall be binding on the insurer unless endorsed on the policy by the insurer, and that the insurer may refuse to endorse the name of any proposed beneficiary who does not appear to the insurer to have an insurable interest in the life of the insured. Such a policy may also provide that if the beneficiary designated in the policy does not surrender the policy with due proof of death within the period stated in the policy, which shall be not less than thirty (30) days after the death of the insured, or if the beneficiary is the estate of the insured or is a minor, or dies before the insured, or is not legally competent to give a valid release, then the insurer may make payment thereunder to the executor or administrator of the insured, or to any of the insured's relatives by blood or legal adoption or connection by marriage, or to any person appearing to the insurer to be equitably entitled

thereto by reason of having been named beneficiary, or by reason of having incurred expense for the maintenance, medical attention or burial of the insured. Such policy may also include a similar provision applicable to any other payment due under the policy. Laws 1957, p. 387, § 4213.

§36-4214. Direct payment of premiums.

In the case of weekly premium policies, there may be a provision that upon proper notice to the insurer, while premiums on the policy are not in default beyond the grace period, of the intention to pay future premiums directly to the insurer at its home office or any office designated by the insurer for the purpose, the insurer will, at the end of each period of a year from the due date of the first premium so paid, for which period such premiums are so paid continuously without default beyond the grace period, refund a stated percentage of the premiums in an amount which fairly represents the savings in collection expense.

Laws 1957, p. 387, § 4214.

§36-4215. Conversion.

There may be a provision in the case of industrial policies granting to the insured, upon proper written request and upon presentation of evidence of insurability satisfactory to the insurer, the privilege of converting any industrial insurance policy to any form of life insurance with less frequent premium payments regularly issued by the insurer, in accordance with terms and conditions agreed upon with the insurer. The privilege of making such conversion need be granted only if the insurer's industrial policies on the life insured, in force as premium paying insurance and on which conversion is requested, grant benefits in event of death, exclusive of additional accidental death benefits and exclusive of any dividend additions, in an amount not less than the minimum amount of such insurance with less frequent premium payments issued by the insurer at the age of the insured on the plan of industrial or ordinary insurance desired.

Laws 1957, p. 387, § 4215.

§36-4216. Title of policy.

There shall be a title on the face of each such policy briefly describing its form.

Laws 1957, p. 388, § 4216.

§36-4217. Provisions inapplicable to single premium or term policies.

Any of the provisions required by Sections 4214 to 4216, inclusive, of this article or any portion thereof which are not applicable to single premium or term policies or to policies issued

or granted pursuant to nonforfeiture provisions shall to that extent not be incorporated therein.

Laws 1957, p. 388, § 4217.

§36-4218. Prohibited provisions.

No policy of industrial insurance shall contain any of the following provisions:

1. A provision by which the insurer may deny liability under the policy for the reason that the insured has previously obtained other insurance from the same insurer.

2. A provision giving the insurer the right to declare the policy void because the insured has had any disease or ailment, whether specified or not, or because the insured has received institutional, hospital, medical or surgical treatment or attention, except a provision which gives the insurer the right to declare the policy void if the insured has, within two (2) years prior to the issuance of the policy, received institutional, hospital, medical or surgical treatment or attention and if the insured or claimant under the policy fails to show that the condition occasioning such treatment or attention was not of a serious nature or was not material to the risk.

3. A provision giving the insurer the right to declare the policy void because the insured has been rejected for insurance, unless such right be conditioned upon a showing by the insurer that knowledge of such rejection would have led to a refusal by the insurer to make such contract.

Laws 1957, p. 388, § 4218.

§36-4250. Rate filing - Definitions.

A. On or after the effective date of this act, pursuant to the provisions of this section and any other applicable section of Title 36 of the Oklahoma Statutes, every health benefit plan shall file all group and individual initial rates and group and individual rate adjustments with the Insurance Commissioner. If the Commissioner determines that the initial rate or rate adjustment is unreasonable, excessive, unjustified or unfairly discriminatory, the Commissioner shall make a written decision stating the reason or reasons for the determination, and shall deliver a copy of the determination to the company within thirty (30) calendar days unless the Commissioner extends the determination period for an additional thirty (30) calendar days.

B. 1. For purposes of this section, "health benefit plan" means a plan that:

- a. provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, and

- b. is offered by any insurance company, group hospital service corporation, or health maintenance organization that delivers or issues for delivery an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an evidence of coverage, or, to the extent permitted by the Employee Retirement Income Security Act of 1974, 29 U.S.C., Section 1001 et seq., by a multiple employer welfare arrangement as defined in Section 3 of the Employee Retirement Income Security Act of 1974, or any other analogous benefit arrangement, whether the payment is fixed or by indemnity.
2. The term "health benefit plan" shall not include:
- a. a plan that provides coverage:
 - (1) only for a specified disease or diseases or under an individual limited benefit policy,
 - (2) only for accidental death or dismemberment,
 - (3) for dental or vision care,
 - (4) a hospital confinement indemnity policy or other fixed indemnity insurance,
 - (5) disability income insurance or a combination of accident-only and disability income insurance, or
 - (6) as a supplement to liability insurance,
 - b. a Medicare supplemental policy as defined by Section 1882(g)(1) of the Social Security Act (42 U.S.C., Section 1395ss),
 - c. workers' compensation insurance coverage,
 - d. medical payment insurance issued as part of a motor vehicle insurance policy,
 - e. a long-term care policy, including a nursing home fixed indemnity policy, unless a determination is made that the policy provides benefit coverage so comprehensive that the policy meets the definition of a health benefit plan,
 - f. short-term health insurance issued on a nonrenewable basis with duration of six (6) months or less,
 - g. policy issued under Title XVIII, or
 - h. a plan issued to any person, firm, corporation, partnership, limited liability company or association that is actively engaged in business and that, on at least fifty percent (50%) of its working days during the preceding calendar quarter, employed more than fifty (50) eligible employees.

Added by Laws 2011, c. 278, § 29. Amended by Laws 2011, c. 360, § 24.

§36-4400. Criteria for inflation protection coverage.

A. In accordance with Section 6021 of the Deficit Reduction Act of 2005 (P.L. 109-171) and any applicable provision relating to the Oklahoma Long-Term Care Insurance Partnership Program, any policy intended to meet the requirements under such Program must meet the following criteria for inflation protection coverage:

1. For a person who is less than sixty-one (61) years of age as of the date of purchase of the Partnership policy, such policy provides annual inflation protection of at least three percent (3%) per year compounded annually or a rate, compounded annually, that is based upon changes in the consumer price index;

2. For a person who is at least sixty-one (61) years of age but less than seventy-six (76) years of age as of the date of purchase of the Partnership policy, such policy provides annual inflation protection of at least three percent (3%) simple or a rate that is based on the annual consumer price index;

3. For a person who is at least seventy-six (76) years of age as of the date of purchase of the Partnership policy, such policy may provide inflation protection.

B. Persons who purchase a Partnership policy that meets the inflation protection criteria in subsection A of this section may adjust their inflation protection as they age. Their policies will maintain Partnership status as long as the inflation protection continues to meet the minimum requirements for their attained age.

C. For the purposes of this section, "consumer price index" means the consumer price index for all urban consumers as determined by the Bureau of Labor Statistics within the United States Department of Labor. The Insurance Commissioner may approve an alternative index to be used in place of the consumer price index or alternative inflation protection programs developed by the insurer if the Commissioner deems that such programs would meet the intent of this section.

Added by Laws 2014, c. 99, § 1, eff. Nov. 1, 2014.

§36-4401. Scope of article.

This article shall apply to all insurance companies, foreign and domestic, including mutual benefit associations licensed pursuant to Article 24, limited stock life, accident and health insurers licensed pursuant to Article 25, reciprocal inter-insurance exchanges licensed pursuant to Article 29, and Lloyd's insurers licensed pursuant to Article 30, hereinafter referred to in this article as "the insurer" or "insurer," issuing policies of insurance against loss or expense from sickness, or from bodily injury or death by accident.

Laws 1957, p. 388, § 4401.

§36-4402. Accident and health policies; filing.

On and after the effective date of this Code no policy of insurance against loss or expense from the sickness, or from the bodily injury or death of the insured by accident shall be issued or delivered to any person in this state, nor shall any application, rider or endorsement be used in connection therewith until a copy of the form thereof, and of the classification of risks, and the premium rates pertaining thereto, have been filed with the Insurance Commissioner. If the Insurance Commissioner disapproves the policy, application, rider or endorsement form, said Commissioner shall make a written decision stating the reason or reasons therefor, and shall deliver a copy thereof to the company, and it shall be unlawful for any such insurer to use any such form in the state. Any such insurer shall have twenty (20) days from the date of receipt of the notice of disapproval in which to request a hearing on such disapproval.

Laws 1957, p. 388, § 4402.

§36-4403. Definition of accident and health insurance policy.

The term "policy of accident and health insurance" as used herein includes any policy or contract insuring against loss resulting from sickness, or from bodily injury or death by accident or both. Provided, however, the term does not include coverage provided under a limited benefit insurance policy or contract as defined in Section 4403.1 of this title.

Added by Laws 1957, p. 388, § 4403. Amended by Laws 1996, c. 246, § 10, eff. July 1, 1996.

§36-4403.1. Definition of limited benefit insurance policy.

A. 1. "Limited benefit insurance" means a policy or contract designed to be purchased individually or to supplement major medical accident and health insurance and which only provides coverage that is less than the minimum standard for benefits required under basic hospital expense coverage or basic medical-surgical expense coverage.

2. A limited benefit insurance policy or contract may specify a waiting period for coverage, maximum benefits, maximum length of coverage, and an exact definition of the disease covered.

B. Nothing in this section shall increase, limit, or remove jurisdiction of the Insurance Commissioner over limited benefit insurance.

Added by Laws 1996, c. 246, § 11, eff. July 1, 1996.

§36-4404. Form of policy.

A. No policy of individual accident and health insurance shall be delivered or issued for delivery to any person in this state unless:

1. the entire money and other considerations therefor are expressed therein;

2. the time at which the insurance takes effect and terminates is expressed therein;

3. it purports to insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family who shall be deemed the policyholder, any two or more eligible members of that family, including husband, wife, dependent children or any children under a specified age which shall not exceed twenty-two (22) years and any other person dependent upon the policyholder;

4. the style, arrangement and overall appearance of the policy give no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and of any endorsement or attached papers is plainly printed in lightfaced type of a style in general use, the size of which shall be uniform and not less than ten-point with a lowercase unspaced alphabet length not less than one hundred twenty points (the "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description if any, and captions and subcaptions); when a policy is renewable only at the option of the company, such fact shall be made known in prominent lettering on the face of the policy;

5. the exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in Section 4405 of this article, are printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "Exceptions," or "Exceptions and Reductions," provided that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies;

6. each such form, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page thereof;

7. it contains no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short rate table filed with the Insurance Commissioner; and

8. in such policies, except accident insurance only policies, in which the insurer reserves the right to refuse renewal on an individual basis, it shall provide, in substance, in a provision thereof or in an endorsement thereon or in a rider attached thereto, that, subject to the right to terminate the policy upon nonpayment of premium when due, such right to refuse renewal may not be

exercised so as to take effect before the renewal date occurring on, or after and nearest, each anniversary (or in the case of lapse and reinstatement at the renewal date occurring on, or after and nearest, each anniversary of the last reinstatement) and that any refusal of renewal shall be without prejudice to any claim originating while the policy is in force. (The parenthetical reference to lapse and reinstatement may be omitted at the option of the insurer.)

B. If the terms of any individual or franchise accident and health insurance policy cover services within the lawful scope of practice of a licensed psychologist then:

1. such services may be performed by any person licensed to do so under the "Psychologists Licensing Act," Title 59 of the Oklahoma Statutes, Sections 1351 through 1375.

2. selection of a licensed psychologist may be made by the insured at his option and, provided other conditions of the policy are met, reimbursement shall not be denied when service is rendered by a person so licensed.

3. the provisions of this act shall apply to the policies and contracts of insurance, which are delivered, amended, ratified, or issued for delivery in Oklahoma after this act takes effect.

4. any provision, exclusion, or limitation of a policy that denies an insured the privilege of selecting a licensed psychologist shall, to the extent of the denial, be void, but such void provision shall not affect the validity of the other provisions of the policy.

C. If any policy is issued by an insurer domiciled in this state for delivery to a person residing in another state, and if the official having responsibility for the administration of the insurance laws of such other state shall have advised the Insurance Commissioner that any such policy is not subject to approval or disapproval by such official, the Insurance Commissioner may by ruling require that such policy meet the standards set forth in subsection A of this section and in Section 4405.

Laws 1957, p. 389, § 4404; Laws 1971, c. 183, § 1.

§36-4405. Accident and health policy provisions.

A. Required Provisions. Except as provided in subsection D of this section, each such policy delivered or issued for delivery to any person in this state shall contain the provisions specified in this subsection in the words in which the same appear in this section; provided, however, that the insurer may, at its option, substitute for one or more of such provisions corresponding provisions of different wording approved by the Insurance Commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Such provisions shall be preceded individually by the caption appearing in this subsection or, at the option of the insurer, by such appropriate individual or

group captions or subcaptions as the Insurance Commissioner may approve.

1. A provision as follows: ENTIRE CONTRACT; CHANGES: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

2. A provision as follows: TIME LIMIT ON CERTAIN DEFENSES:

(a) After two (2) years from the date of issue of this policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two-year period. The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two-year period, nor limit the application of paragraphs 1, 2, 3, 4 and 5 of subsection B of this section in the event of misstatement with respect to age or occupation or other insurance. A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (i) until at least fifty (50) years of age or, (ii) in the case of a policy issued to a person older than forty-four (44) years of age, for at least five (5) years from its date of issue, may contain in lieu of the foregoing the following provisions (from which the clause in parentheses may be omitted at the insurer's option) under the caption "Incontestable". After this policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.

(b) No claim for loss incurred or disability (as defined in the policy) commencing after two (2) years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

3. A provision as follows: GRACE PERIOD:

(a) A grace period of _____ (insert a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

(b) A policy in which the insurer reserves the right to refuse renewal shall have, at the beginning of the above provision, "Unless not less than thirty (30) days prior to the premium due date the

insurer has delivered to the insured or has mailed to his last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted."

4. A provision as follows: REINSTATEMENT:

(a) If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt, unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

(b) The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (i) until at least fifty (50) years of age or, (ii) in the case of a policy issued to a person older than forty-four (44) years of age, for at least five (5) years from its date of issue.

5. A provision as follows: NOTICE OF CLAIM:

(a) Written notice of claim must be given to the insurer within twenty (20) days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at _____ (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

(b) In a policy providing a loss-of-time benefit which may be payable for at least two (2) years, an insurer may, at its option, insert the following between the first and second sentences of the above provision: Subject to the qualifications set forth below, if

the insured suffers loss of time on account of disability for which indemnity may be payable for at least two (2) years, he shall, at least once in every six (6) months after having given notice of claim, give to the insurer notice of continuance of said disability except in the event of legal incapacity. The period of six (6) months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six (6) months preceding the date on which such notice is actually given.

6. A provision as follows: CLAIM FORMS: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

7. A provision as follows: PROOFS OF LOSS: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which the policy provides any periodic payment contingent upon continuing loss within ninety (90) days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.

8. A provision as follows: TIME OF PAYMENT OF CLAIMS: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid _____ (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

9. A provision as follows: PAYMENT OF CLAIMS:

(a) Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of

payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

(b) The following provisions, or either of them, may be included with the foregoing provision at the option of the insurer: If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding \$_____ (insert an amount which shall not exceed One Thousand Dollars (\$1,000.00)), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.

Subject to any written direction of the insured in the application or otherwise, all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person.

10. A provision as follows: PHYSICAL EXAMINATION, AUTOPSY:

The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

11. A provision as follows: LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

12. A provision as follows: CHANGE OF BENEFICIARY: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

The first clause of this provision, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option.

B. Other provisions. Except as provided in subsection D of this section, no such policy delivered or issued for delivery to any person in this state shall contain provisions respecting the matters set forth below unless such provisions are in the words in which the same appear in this section; provided, however, that the insurer may, at its option, use in lieu of any such provision a corresponding provision of different wording approved by the Insurance Commissioner which is not less favorable in any respect to the insured or the beneficiary. Any such provision contained in the policy shall be preceded individually by the appropriate caption appearing in this subsection or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the Insurance Commissioner may approve.

1. A provision as follows: CHANGE OF OCCUPATION: If the insured be injured or contract sickness after having changed his occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes his occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change of occupation.

2. A provision as follows: MISSTATEMENT OF AGE: If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.

3. A provision as follows: OTHER INSURANCE IN THIS INSURER:
If an accident or health or accident and health policy or policies previously issued by the insurer to the insured be in force concurrently herewith, making the aggregate indemnity for _____ (insert type of coverage or coverages) in excess of \$ _____ (insert

maximum limit of indemnity or indemnities), the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to his estate; or, in lieu thereof: Insurance effective at any one time on the insured under a like policy or policies in this insurer is limited to the one such policy elected by the insured, his beneficiary or his estate, as the case may be, and the insurer will return all premiums paid for all other such policies.

4. A provision as follows: INSURANCE WITH OTHER INSURERS:

(a) If there be other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

(b) If the foregoing policy provision is included in a policy which also contains the next following policy provision, there shall be added to the caption of the foregoing provision the phrase "Expense Incurred Benefits". The insurer may, at its option, include in this provision a definition of "other valid coverage", approved as to form by the Insurance Commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the Insurance Commissioner. In the absence of such definition such term shall not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute), whether provided by a governmental agency or otherwise, shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing

policy provision no third party liability coverage shall be included as "other valid coverage".

5. A provision as follows: INSURANCE WITH OTHER INSURERS:

(a) If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such portion of the indemnities otherwise provided hereunder for such loss as the like indemnities, of which the insurer had notice (including the indemnities under this policy), bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro rata portion for the indemnities thus determined.

(b) If the foregoing policy provision is included in a policy which also contains the next preceding policy provision, there shall be added to the caption of the foregoing provision the phrase "Other Benefits". The insurer may, at its option, include in this provision a definition of "other valid coverage", approved as to form by the Insurance Commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and to any other coverage the inclusion of which may be approved by the Insurance Commissioner. In the absence of such definition, such term shall not include group insurance or benefits provided by union welfare plans or by employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute) whether provided by a governmental agency or otherwise, shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision, no third party liability coverage shall be included as "other valid coverage".

6. A provision as follows: RELATION OF EARNINGS TO INSURANCE: (a) If the payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or his average monthly earnings for the period of two (2) years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid

during such two (2) years as shall exceed the pro rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly benefits payable under all such coverage upon the insured below the sum of Two Hundred Dollars (\$200.00) or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time.

(b) The foregoing policy provision may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (i) until at least fifty (50) years of age or, (ii) in the case of a policy issued to a person older than forty-four (44) years of age, for at least five (5) years from its date of issue. The insurer may, at its option, include in this provision a definition of "valid loss of time coverage", approved as to form by the Insurance Commissioner, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, or to any other coverage the inclusion of which may be approved by the Insurance Commissioner or any combination of such coverages. In the absence of such definition, such term shall not include any coverage provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute), or benefits provided by union welfare plans or by employer or employee benefit organizations.

7. A provision as follows: UNPAID PREMIUM: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

8. A provision as follows: CONFORMITY WITH STATE STATUTES: Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such states.

9. A provision as follows: ILLEGAL OCCUPATION: The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

10. A provision as follows: NARCOTICS: The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being under the influence of any narcotic unless administered on the advice of a physician.

11. A provision as follows: CONTINUITY OF COVERAGE: If coverage otherwise terminates as to covered family members, other than for nonpayment of premium, nonrenewal of the policy or the expiration of the term for which the policy is issued, a covered

person (other than one eligible for Medicare or any other similar federal program), including the spouse and any covered dependent child of the last-named insured or the representative of such child, shall have the right to the continuation of coverage under provisions which, at the option of the insurer, are consistent with either the continuation of the policy with the person exercising the right of continuation designated as the named insured; or the issuance of a converted policy with the person exercising the conversion right designated as the named insured. Where continuation of coverage or conversion is made in the name of the spouse of the named insured, such coverage may, at the option of such spouse, include covered dependent children for whom such spouse has responsibility for care and support. The person who accepts the conversion policy shall become the insured and pay the premiums direct to the insurer.

(a) Coverage continued through the issuance of a converted policy shall consist of a form of coverage then being offered by the insurer as a conversion policy in the jurisdiction where the person exercising the conversion right resides. Continued and converted coverages, other than those provided through the exercise of continuation or conversion rights contained in optionally renewable or limited right of renewal contracts, shall contain provisions under which the person exercising the continuation or conversion shall have the right to renew the coverage until the attainment of the age of eligibility for Medicare or any other similar federal or state health insurance program subject to the right of the insurer to nonrenew all such policies in this state as a class, or, other renewal provisions that are not less favorable to the insured than those contained in the policy from which conversion is exercised.

(b) Coverage provided through continuation or conversion shall be without additional evidence of insurability except as to overinsurance, and shall not impose any preexisting condition limitations or other contractual time limitations other than those remaining unexpired under the policy or contract from which continuation or conversion is exercised.

(c) Benefits otherwise payable under a converted policy may be reduced so they are not, during the first policy year of the converted policy, in excess of those that would have been payable had the coverage under the policy from which conversion is exercised not terminated, and by the amount of benefits, if any, payable as to the same loss under the policy from which conversion is exercised.

(d) The insurer shall not be required to issue a converted policy if at the time of application therefor other coverage exists under other health insurance policies, hospital or medical service plan corporation contracts, health maintenance organization plans or self-insured health benefit plans providing similar benefits, or if the applicant for the converted policy is eligible for coverage

under a group policy or contract providing similar benefits, or is provided with similar benefits required by any statute, or is covered under any national, state or governmental plan, which together with the converted policy would result in overinsurance according to the insurer's underwriting standards.

The provisions of this paragraph shall apply to individual family health insurance policies providing hospital, surgical and medical expense benefits or hospital confinement indemnity benefits, individual family hospital and medical service plan corporation contracts, and family health maintenance organization contracts, delivered or issued for delivery in the State of Oklahoma but shall not apply to disability income policies, accidental death or dismemberment policies nor to single-term, nonrenewable policies.

C. 1. The terms "noncancelable" and "guaranteed renewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums set forth in the policy until a person is at least fifty (50) years of age, or in the case of a policy issued to a person older than forty-four (44) years of age, for at least five (5) years from its date of issue, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force.

2. Except as provided in paragraph 1 of this subsection, the term "guaranteed renewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums by the insured until fifty (50) years of age, or in the case of a policy issued to an insured who is older than forty-four (44) years of age, for at least five (5) years from its date of issue, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may make changes in premium rates by classes.

The foregoing limitation on the use of the term "noncancelable" shall also apply to any synonymous term such as "guaranteed continuable".

Nothing contained in this subsection is intended to restrict the development of policies having other guarantees of renewability, or to prevent the accurate description of their terms of renewability or the classification of such policies as guaranteed renewable or noncancelable for any period during which they may actually be such, provided the terms used to describe them in policy contracts and advertising are not such as may readily be confused with the above terms.

D. Inapplicable or Inconsistent Provisions. If any provision of this section is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the Insurance Commissioner, shall omit from such policy any inapplicable provision

or part of a provision, and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

E. Order of Certain Policy Provisions. The provisions which are the subject of subsections A and B of this section, or any corresponding provisions which are used in lieu thereof in accordance with such subsections, shall be printed in the consecutive order of the provisions in such subsections or, at the option of the insurer, any such provision may appear as a unit in any part of the policy, with other provisions to which it may be logically related, provided the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered or issued.

F. Third Party Ownership. The word "insured", as used in this article, shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering the insured or from being entitled under such a policy to any indemnities, benefits and rights provided therein.

G. Employer Designated as Beneficiary. No employer shall be designated or appointed as beneficiary of an employee or receive any benefits under an individual or group accident and health policy solely by reason of the employer-employee relationship; provided, however, this subsection shall not prevent the designation or appointment of an employer as beneficiary under a policy of accident and health insurance on any valuable or key employee of such employer.

H. Requirements of Other Jurisdictions. 1. Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this state, may contain any provision which is not less favorable to the insured or the beneficiary than the provisions of this article and which is prescribed or required by the law of the state under which the insurer is organized.

2. Any policy of a domestic insurer may, when issued for delivery in any other state or country, contain any provision permitted or required by the laws of such other state or country.

I. Filing Procedure. The Insurance Commissioner may make such reasonable rules and regulations concerning the procedure for the filing or submission of policies subject to this article as are necessary, proper or advisable to the administration of this article. This provision shall not abridge any other authority granted the Insurance Commissioner by law.

Amended by Laws 1984, c. 149, § 16, eff. Nov. 1, 1984.

§36-4405.1. Health benefit plans - Credentialing or recredentialing of physicians and other health care providers.

A. As used in this section:

1. a. "Health benefit plan" or "plan" means:

- (1) group hospital or medical insurance coverages,
- (2) not-for-profit hospital or medical service or indemnity plans,
- (3) prepaid health plans,
- (4) health maintenance organizations,
- (5) preferred provider plans,
- (6) multiple employer welfare arrangements (MEWA), or
- (7) employer self-insured plans that are not exempt pursuant to the federal Employee Retirement Income Security Act of 1974 (ERISA) provisions, and

b. the term health benefit plan shall not include:

- (1) individual plans,
- (2) plans that only provide coverage for a specified disease, accidental death, or dismemberment for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury or as a supplement to liability insurance,
- (3) Medicare supplemental policies as defined in Section 1882(g)(1) of the federal Social Security Act (42 U.S.C., Section 1395ss),
- (4) workers' compensation insurance coverage,
- (5) medical payment insurance issued as a part of a motor vehicle insurance policy, or
- (6) long-term care policies, including nursing home fixed indemnity policies, unless the Insurance Commissioner determines that the policy provides comprehensive benefit coverage sufficient to meet the definition of a health benefit plan; and

2. "Credentialing" or "rec credentialing", as applied to physicians and other health care providers, means the process of accessing and validating the qualifications of such persons to provide health care services to the beneficiaries of a health benefit plan. Credentialing or rec credentialing may include, but is not limited to, an evaluation of licensure status, education, training, experience, competence and professional judgment.

Credentialing or rec credentialing is a prerequisite to the final decision of a health benefit plan to permit initial or continued participation by a physician or other health care provider.

B. 1. Any health benefit plan that is offered, issued or renewed in this state shall provide for credentialing and rec credentialing of physicians and other health care providers based

on criteria provided in the uniform credentialing application required by Section 1-106.2 of Title 63 of the Oklahoma Statutes.

2. Health benefit plans shall make information on such criteria available to physician and other health care provider applicants, participating physicians, and other participating health care providers and shall provide applicants with a checklist of materials required in the application process.

3. Physicians or other health care providers under consideration to provide health care services under a health benefit plan in this state shall apply for credentialing or recredentialing on the uniform credentialing application and shall provide the documentation as outlined in the plan's checklist of materials required in the application process.

C. A health benefit plan shall determine whether a credentialing or recredentialing application is complete. If an application is determined to be incomplete, the plan shall notify the applicant in writing within ten (10) calendar days of receipt of the application. The written notice shall specify the portion of the application that is causing a delay in processing and explain any additional information or corrections needed.

D. 1. In reviewing the application, the health benefit plan shall evaluate each application according to the plan's checklist of required materials that accompanies the application.

2. When an application is deemed complete, the plan shall initiate requests for primary source verification and malpractice history within seven (7) calendar days.

3. A malpractice carrier shall have twenty-one (21) calendar days within which to respond after receipt of an inquiry from a health benefit plan. Any malpractice carrier that fails to respond to an inquiry within the time frame may be assessed an administrative penalty by the Insurance Commissioner.

E. 1. Upon receipt of primary source verification and malpractice history by the plan, the plan shall determine if the application is a clean application. If the application is deemed clean, a plan shall have forty-five (45) calendar days within which to credential or recredential a physician or other health care provider. As used in this paragraph, "clean application" means an application that has no defect, misstatement of facts, improprieties, including a lack of any required substantiating documentation, or particular circumstance requiring special treatment that impedes prompt credentialing or recredentialing.

2. If a plan is unable to credential or recredential a physician or other health care provider due to an application not being clean, the plan may extend the credentialing or recredentialing process for sixty (60) calendar days. At the end of sixty (60) calendar days, if the plan is awaiting documentation to complete the application, the physician or other health care

provider shall be notified of the reason for the delay by certified mail. The physician or other health care provider may extend the sixty-day period upon written notice to the plan within ten (10) calendar days; otherwise the application shall be deemed withdrawn. In no event shall the entire credentialing or recredentialing process exceed one hundred eighty (180) calendar days.

3. If an application for credentialing or recredentialing is denied, the plan shall notify the applicant in writing the reason for the denial and what corrective actions the applicant may consider within ten (10) calendar days of the determination to deny the application.

4. A health benefit plan shall be prohibited from solely basing a denial of an application for credentialing or recredentialing on the lack of board certification or board eligibility and from adding new requirements solely for the purpose of delaying an application.

5. Any health benefit plan that violates the provisions of this section may be assessed an administrative penalty by the Commissioner.

F. Within thirty-one (31) days after a provider has been credentialed by a health benefit plan following the completion of the credentialing or recredentialing process pursuant to this section, the health benefit plan shall consider the provider in-network for purposes of reimbursement.

Added by Laws 2001, c. 273, § 1, eff. Nov. 1, 2001. Amended by Laws 2002, c. 156, § 1, eff. Nov. 1, 2002; Laws 2015, c. 376, § 1, eff. Nov. 1, 2015; Laws 2024, c. 233, § 1, eff. Nov. 1, 2024.

§36-4406. Conforming to statute.

A. Other Policy Provisions. No policy provision which is not subject to section 4405 of this article shall make a policy, or any portion thereof, less favorable in any respect to the insured or the beneficiary than the provisions thereof which are subject to this article.

B. Policy Conflicting with this Article. A policy delivered or issued for delivery to any person in this state in violation of this article shall be held valid but shall be construed as provided in this article. When any provision in a policy subject to this article is in conflict with any provision of this article, the rights, duties and obligations of the insurer, the insured and the beneficiary shall be governed by the provisions of this article. Laws 1957, p. 396, § 4406.

§36-4407. Application.

A. The insured shall not be bound by any statement made in an application for a policy unless a copy of such application is attached to or endorsed on the policy when issued as a part thereof. If any such policy delivered or issued for delivery to any person in

this state shall be reinstated or renewed, and the insured or the beneficiary or assignee of such policy shall make written request to the insurer for a copy of the application, if any, for such reinstatement or renewal, the insurer shall, within fifteen (15) days after the receipt of such request at its home office or any branch office of the insurer, deliver or mail to the person making such request a copy of such application. If such copy shall not be so delivered or mailed, the insurer shall be precluded from introducing such application as evidence in any action or proceeding based upon or involving such policy or its reinstatement or renewal.

B. No alteration of any written application for any such policy shall be made by any person other than the applicant without his written consent, except that insertions may be made by the insurer, for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

C. The falsity of any statement in the application for any policy covered by this article may not bar the right to recovery thereunder unless such false statement materially affected either the acceptance of the risk or the hazard assumed by the insurer. Laws 1957, p. 396, § 4407.

§36-4408. Notice; waiver.

The acknowledgment by any insurer of the receipt of notice given under any policy covered by this article, or the furnishing of forms for filing proofs of loss, or the acceptance of such proofs, or the investigation of any claim thereunder, shall not operate as a waiver of any of the rights of the insurer in defense of any claim arising under such policy.

Laws 1957, p. 397, § 4408.

§36-4409. Age limit.

If any such policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and if such date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after such date, the coverage provided by the policy will continue in force subject to any right of cancellation until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective, or would have ceased prior to the acceptance of such premium or premiums, then the liability of the insurer shall be limited to the refund, upon request, of all premiums paid for the period not covered by the policy.

Added by Laws 1957, p. 397, § 4409, operative July 1, 1957.

§36-4410. Franchise accident and health insurance law.

Accident and health insurance on a franchise plan is hereby declared to be that form of accident and health insurance issued to:

1. Five or more employees of any corporation, copartnership or individual employer or any governmental corporation, agency or department thereof; or

2. Ten or more members, employees or employees of members of any trade or professional association or of a labor union or of any other association having had an active existence for at least two (2) years where such association or union has a constitution or bylaws and is formed in good faith for purposes other than that of obtaining insurance;

where such persons, with or without their dependents, are issued the same form of an individual policy varying only as to amounts and kinds of coverage applied for by such persons under an arrangement whereby the premiums on such policies may be paid to the insurer periodically by the employer, with or without payroll deductions, or by the association for its members, or by some designated person acting on behalf of such employer or association. The term "employees" as used herein may be deemed to include the officers, managers and employees of the employer and the individual proprietor or partners if the employer is an individual proprietor or partnership.

Laws 1957, p. 397, § 4410.

§36-4411. Nonapplication to certain policies.

Nothing in this article shall apply to or affect:

1. any policy of workers' compensation insurance or any policy of liability insurance with or without supplementary expense coverage therein; or

2. any policy or contract of reinsurance; or

3. any blanket or group policy of insurance except as provided in paragraph F, Section 4405 of this article; or

4. life insurance, endowment or annuity contracts, or contracts supplemental thereto, which contain only such provisions relating to accident and health insurance as (a) provide additional benefits in case of death or dismemberment or loss of sight by accident, as (b) operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant shall become totally and permanently disabled, as defined by the contract or supplemental contract, or as (c) provide additional benefits providing acceleration of life or endowment or annuity benefits in advance of the time they would otherwise be payable, as an indemnity for long-term care which is certified or ordered by a physician, including but not limited to, professional nursing care, medical care

expenses, custodial nursing care, nonnursing custodial care provided in a nursing home or at a residence of the insured or providing such acceleration upon the occurrence of a catastrophic disease or diseases as designated and defined by the policy, provided, no life insurance policy, except industrial life insurance policy and group life insurance policy, shall be issued or delivered in this state which contains or provides accident and health coverage, except as provided by the foregoing (a), (b) and (c). A rider providing additional benefits as described in the foregoing (c) shall conform to the requirements of the Long-Term Care Insurance Act and accompanying regulations. The Insurance Commissioner shall have authority to require appropriate reserves for the rider as is provided for additional reserves in subparagraph (d) of paragraph 3 of Section 1505 of this title. The Insurance Commissioner shall have power to make reasonable rules and regulations concerning such provisions, and contracts or supplemental contracts containing such provisions, and the same shall not be issued or delivered to any person in the state unless and until a copy of the form thereof has been filed with the Insurance Commissioner as required by law. Laws 1957, p. 397, § 4411.

§36-4413. Short title - Health Care Choice Act.

Section 3 of this act shall be known and may be cited as the "Health Care Choice Act".

Added by Laws 2017, c. 362, § 2, eff. Aug. 25, 2017.

§36-4414. Issuance of accident or health policies by insurers not authorized to engage in the insurance business in Oklahoma - Approval process.

A. The Oklahoma Legislature recognizes the need for purchasers of health insurance coverage in this state to have the opportunity to choose health insurance plans that are more affordable and flexible than existing market policies offering accident and health coverage. Therefore, the Oklahoma Legislature seeks to increase the availability of health insurance coverage by allowing insurers authorized to engage in the business of insurance in other states, and not so authorized in Oklahoma, to issue accident and health policies in Oklahoma by granting a limited exemption from Section 606 of Title 36 of the Oklahoma Statutes. Insurers authorized to engage in the business of insurance in other states, and not so authorized in Oklahoma, shall be subject to the following requirements in order to be able to obtain an exemption to Section 606 of Title 36 of the Oklahoma Statutes and to issue accident and health policies in Oklahoma through agents licensed in the state:

1. No insurer authorized to engage in the business of insurance in other states that is not so licensed in Oklahoma may issue an

accident or a health policy pursuant to this section unless it is approved to do so, in writing, by the Insurance Commissioner;

2. An insurer seeking to obtain the written approval described in paragraph 1 of this subsection shall request such approval in the manner required by the Insurance Commissioner, and shall pay any and all fees associated with such application as may be required by the Insurance Commissioner; and

3. In order to first be considered for the written approval from the Insurance Commissioner, an insurer shall be domiciled in a state which has a legislatively approved compact with the State of Oklahoma.

B. Pursuant to the provisions of the Health Care Choice Act, all approved insurers domiciled in a compacting state selling health and accident insurance policies in Oklahoma shall:

1. Offer accident and health insurance policies that contain all mandated health benefits that are required by Oklahoma law to be included in accident or health insurance policies and Health Maintenance Organization (HMO) policies issued in the state and will comply with all other applicable laws pertaining to coverage and coverage decisions;

2. Keep a full and true record of each insurance policy issued to an insured in this state by or on behalf of the insurer, containing such information as may be required by the Insurance Commissioner, which record may be examined at any time within three (3) years after issuance by the Insurance Commissioner;

3. File with the Insurance Commissioner, on or before April 1 of each year, a verified statement of all insurance transacted by the insurer during the preceding calendar year in Oklahoma. The statement shall be on a form prescribed and furnished by the Insurance Commissioner and contain such information as required by the Insurance Commissioner;

4. Issue an insurance policy in this state pursuant to this section through an insurance agent or other person or entity that is licensed in this state, as well as in a state in which the insurer is licensed, to engage in the sale, solicitation or negotiation of accident and/or health insurance in this state, and that is appointed by the insurer for such purpose;

5. Appoint one or more third-party administrators that are licensed in this state, and that have licensed adjusters in this state, that shall be responsible for administering claims under the insurance policies issued by the insurer in this state and be available to answer any questions from insureds under the insurance policies issued by the insurer in this state; and

6. Submit to the jurisdiction of this state and be subject to service of legal process within this state in any action or proceeding against the insurer arising out of any insurance policy issued to an insured policyholder in this state and the Insurance

Commissioner is appointed as its exclusive agent to receive service of legal process.

C. The Insurance Commissioner may only grant the written approval described in paragraph 1 of subsection A of this section to an insurer that:

1. Is properly licensed and has met the requirements for solvency in its domiciliary state to issue accident and health insurance policies;

2. Has met the requirements for market conduct applicable to insurers domiciled in Oklahoma authorized to issue accident and health insurance policies in the state set forth in Title 36 of the Oklahoma Statutes; and

3. Has submitted the policy form that it will issue to insureds in this state for a determination by the Insurance Commissioner that the policy form is in compliance with all laws and regulations in this state applicable to health insurance policies.

D. The Insurance Commissioner for the State of Oklahoma shall be required to obtain verification in writing by the regulating authority of the domiciliary state, certifying that the insurer has met the financial solvency requirements of the insurer's domiciliary state. No insurer domiciled in a compacting state may be approved to sell health and accident insurance policies in Oklahoma without such verification.

E. The Insurance Commissioner may require an insurer to reapply for the written approval described in paragraph 1 of subsection A of this section on an annual basis, or as often as the Insurance Commissioner deems prudent. Reapplication shall be in the form and manner required by the Insurance Commissioner.

F. The Insurance Commissioner may, as a condition to providing an insurer with the written approval described in paragraph 1 of subsection A of this section, impose on the insurer any additional requirement that the Insurance Commissioner deems necessary.

G. The Insurance Commissioner may negotiate one or more compacts with other states to allow insurers domiciled in such compacting state that obtain the written approval from the Insurance Commissioner described in paragraph 1 of subsection A of this section to sell policies of accident and health insurance in Oklahoma. Such compacts shall provide for appropriate protection of Oklahoma consumers by requiring the Commissioner to regulate the compliance to Oklahoma laws and regulations, and market conduct of the insurers pursuant to compact provisions. The terms of any such compact shall be presumed a valid exercise of the discretionary authority of the Commissioner. The compact shall be required to be approved by the Legislature by adoption of a joint resolution, provided that the joint resolution becomes law in accordance with Section 11 of Article VI of the Oklahoma Constitution. Joint resolutions introduced for such purpose shall not be subject to

regular legislative deadlines and shall be limited to such provisions as may be necessary for approval of a compact. The Legislature retains the authority to approve or not approve a compact with a state.

H. The Insurance Commissioner may require every approved insurer to submit to a market conduct examination. Any examination by the Commissioner of the regulatory compliance or market conduct of any insurer domiciled in a compacting state seeking to offer health benefit plans in this state, or who has been given approval to offer health benefit plans in this state, shall be conducted in the same manner and under the same terms and conditions as examinations of companies located in this state.

I. An insurer domiciled in a compacting state is required to provide Oklahoma state-mandated health benefits and to comply with all other applicable laws that apply to Oklahoma accident and health insurers including coverage of services and coverage decisions.

J. All approved insurers domiciled in a compacting state selling health and accident insurance policies in Oklahoma must comply with the Unfair Claims Settlement Practices Act, Health Care Freedom of Choice Act, Genetic Nondiscrimination in Insurance Act, Hospital and Medical Services Utilization Review Act and all requirements found in Sections 4401 through 4411 of Title 36 of the Oklahoma Statutes. All Health Maintenance Organizations shall be subject to and comply with the Health Maintenance Organization Act of 2003.

K. Each written application for purchase of a policy offered by an insurer domiciled in a compacting state pursuant to the Health Care Choice Act shall contain the following language in boldface type at the beginning of the document:

"This policy may be subject, in part, to the laws of (insert state where the master policy is filed); in particular, all of the premium rating laws applicable to policies filed in Oklahoma do not apply to this policy. This may result in increases in your premium at renewal that would not be permissible in a policy that was issued by an Oklahoma domestic insurer. For information concerning health insurance coverage under a policy issued by an Oklahoma insurer, please consult your insurance agent or the Oklahoma Department of Insurance."

L. Each policy issued pursuant to the Health Care Choice Act by an insurer domiciled in a compacting state shall contain the following language in boldface type at the beginning of the document:

"The benefits provided under this policy may be affected, in part, by the laws of a state other than Oklahoma; however, they must include the Oklahoma state-mandated benefits, including coverage of services, and coverage decisions, and must comply with all other applicable Oklahoma and federal laws. Please consult with your

insurance agent to determine which health benefits are included or excluded under this policy."

M. Approved insurers domiciled in a compacting state selling health and accident insurance policies in Oklahoma shall be subject to payment of any applicable premium taxes pursuant to Section 624 of Title 36 of the Oklahoma Statutes.

N. Approved insurers domiciled in a compacting state selling health and accident insurance policies in Oklahoma shall participate on a nondiscriminatory basis and in the same manner as admitted participating insurers in the Oklahoma Life and Health Insurance Guaranty Association Act.

O. Approved insurers domiciled in a compacting state selling health and accident insurance policies in Oklahoma shall participate on a nondiscriminatory basis and in the same manner as admitted participating insurers in any existing or future Health Insurance High Risk Pool created by or for the State of Oklahoma.

P. The Commissioner shall promulgate rules necessary for the administration and implementation of the Health Care Choice Act, which rules shall specify how the requirements set forth in subsection A of this section shall be implemented.

Added by Laws 2017, c. 362, § 3.

§36-4415. Definitions - Standard health benefit plans for individuals under 40 years of age - Coverage disclosure statements and acknowledgments - Rate filings - Rules.

A. As used in this section:

1. "Health carrier" means any entity or insurer authorized under Title 36 of the Oklahoma Statutes to provide accident or health insurance or health benefits in this state and any entity or person engaged in the business of making contracts of accident or health insurance;

2. "Standard health benefit plan" means an accident or health insurance policy that does not offer or provide state-mandated health benefits but that provides creditable coverage and is issued to an individual under forty (40) years of age; and

3. a. "State-mandated health benefits" means coverage for health care services or benefits, required by state law or state regulations, requiring the reimbursement or utilization related to a specific illness, injury, or condition of the covered person, including those provisions listed in Sections 6060 through 6060.11 of Title 36 of the Oklahoma Statutes.

b. "State-mandated health benefits" does not mean those benefits found in Sections 4401 through 4411 and 4501 through 4513 of Title 36 of the Oklahoma Statutes.

B. 1. A health carrier may offer one or more standard health benefit plans to individuals under forty (40) years of age.

2. Each application and health benefit plan issued pursuant to this section shall contain the following language at the beginning of the document in bold type:

"This standard health benefit plan does not provide state-mandated health benefits normally required in accident and health insurance policies in the State of Oklahoma. This standard health benefit plan may provide a more affordable health insurance policy for you although, at the same time, it may provide you with fewer health benefits than those normally included as state-mandated health benefits in policies in the State of Oklahoma."

C. An insurer providing a standard health benefit plan shall provide a proposed policyholder or policyholder with a written disclosure statement that:

1. Lists those state-mandated health benefits not included under the standard health benefit plan and acknowledges that the plan being purchased does not provide those benefits; and

2. Provides a notice that purchase of the plan may limit the future coverage options of the policyholder in the event the health of the policyholder changes and needed benefits are not available under the standard health benefit plan.

D. Each applicant for initial coverage and each policyholder on renewal of coverage shall sign the disclosure statement provided by the insurer under subsection C of this section and return the statement to the insurer. An insurer shall:

1. Retain the signed disclosure statement in the records of the insurer; and

2. Upon request of the Insurance Commissioner, provide the signed disclosure statement to the Oklahoma Insurance Department.

E. An insurer that offers one or more standard health benefit plans as provided in this section shall also offer at least one accident or health insurance policy with state-mandated health benefits that is otherwise authorized by Title 36 of the Oklahoma Statutes.

F. A health carrier shall file, for informational purposes only, with the Oklahoma Insurance Department the rates to be used with a standard health benefit plan.

G. The Insurance Commissioner shall adopt rules necessary to implement the provisions of this section.

Added by Laws 2009, c. 128, § 4, eff. Nov. 1, 2009.

§36-4419. Short-term, limited-duration insurance policies - Limitations on benefits provided.

A. For the purposes of this section "short-term, limited-duration insurance" or "STLDI" means individual health insurance coverage provided pursuant to a contract with an insurer that has an expiration date specified in the contract that is less than twelve (12) months after the original effective date of the contract and,

taking into account renewals or extensions, has a duration of no longer than thirty-six (36) months in total.

B. An STLDI policy shall not be subject to the continuation provisions of the Health Insurance Portability and Accountability Act of 1996, and shall be exempt from medical loss ratio calculations associated with individual accident and health insurance issued within this state.

C. No STLDI policy shall be deemed to be included under the definition of group accident and health insurance issued or renewed inside or outside of this state and covering persons residing in this state.

D. The benefits provided by an STLDI policy may be limited as follows:

1. An STLDI policy shall not be required to contain one or more of the mandated accident and health insurance benefits otherwise required by Title 36 of the Oklahoma Statutes; and

2. An STLDI policy shall include the definitions of individual accident and health insurance with respect to major medical benefits and standard provisions or rights of coverage.

E. An applicant for an STLDI policy shall be provided, at the time of application and in addition to any notice required by applicable federal law or regulation, a written notice that one or more of the benefits mandated by Oklahoma law is not included in the STLDI policy.

1. The notice shall specify the essential health benefits that are included in the STLDI policy. For purposes of this subsection, "essential health benefits" means those benefits set forth in 42 U.S.C., Section 18022(b).

2. The notice shall specifically list the accident and health insurance benefits otherwise required to be covered by Title 36 of the Oklahoma Statutes that will not be covered.

3. The insurer shall retain a signed copy of this notice on file as a part of the original application as evidence that the insured has acknowledged such notice.

4. Such signed copy may be in original form, electronic file form or in any other reproducible file form as may be consistent with the insurer's method of retaining application copies.

F. An STLDI policy may offer various optional combinations of coverage at additional premiums for each optional benefit offered.

G. STLDI policies issued in Oklahoma shall be subject to the filing requirements of Section 4402 of Title 36 of the Oklahoma Statutes.

H. Any individual insured under an STLDI policy shall be issued an identification card which clearly indicates that the STLDI policy is a limited duration policy not subject to Affordable Care Act requirements.

Added by Laws 2019, c. 418, § 1, eff. Nov. 1, 2019.

§36-4421. Short title.

Section 4421 et seq. of this title shall be a part of the Insurance Code and shall be known and may be cited as the "Long-Term Care Insurance Act".

Added by Laws 1987, c. 175, § 25, eff. Nov. 1, 1987. Amended by Laws 1989, c. 107, § 1, eff. Nov. 1, 1989; Laws 1995, c. 244, § 1, eff. Nov. 1, 1995.

§36-4422. Purpose of act.

The purpose of the Long-Term Care Insurance Act is to promote the public interest, to promote the availability of long-term care insurance policies, to protect applicants for long-term care insurance from unfair or deceptive sales or enrollment practices, to establish standards for long-term care insurance, to facilitate public understanding and comparison of long-term care insurance policies, and to facilitate flexibility and innovation in the development of long-term care insurance coverage.

Added by Laws 1987, c. 175, § 26, eff. Nov. 1, 1987.

§36-4423. Application of act.

A. The requirements of the Long-Term Care Insurance Act shall apply to policies, other than life care community policies delivered or issued for delivery in this state on or after November 1, 1987. The requirements of the Long-Term Care Insurance Act shall apply to life care community policies delivered or issued for delivery in this state on or after November 1, 1989.

B. Notwithstanding any other provision, the Long-Term Care Insurance Act shall not apply to the following:

1. Residential care homes licensed pursuant to the Oklahoma Residential Care Act;

2. Assisted living centers and continuum of care facilities licensed pursuant to the Oklahoma Continuum of Care and Assisted Living Act; or

3. Facilities licensed pursuant to the Oklahoma Nursing Home Care Act.

C. The Long-Term Care Insurance Act is not intended to supersede the obligations of entities subject to said act to comply with the substance of other applicable insurance laws insofar as they do not conflict with the Long-Term Care Insurance Act, except that laws and regulations designed and intended to apply to Medicare supplement insurance policies shall not apply to long-term care insurance. A policy which is not advertised, marketed or offered as long-term care insurance need not meet the requirements of the Long-Term Care Insurance Act. The Long-Term Care Insurance Act is not intended to require life care communities to be licensed insurers. Life care communities which are not licensed insurers shall not be

subject to the provisions of the Insurance Code or the jurisdiction of the Insurance Commissioner, except as provided in the Long-Term Care Insurance Act.

Added by Laws 1987, c. 175, § 27, eff. Nov. 1, 1987. Amended by Laws 1989, c. 107, § 2, eff. Nov. 1, 1989; Laws 2000, c. 171, § 1, emerg. eff. May 2, 2000.

§36-4424. Definitions.

Unless the context requires otherwise, the definitions in this section apply throughout the Long-Term Care Insurance Act.

1. a. "Long-term care insurance" means any insurance policy, certificate or rider, including qualified long-term care insurance contracts and long-term care partnership program contracts, which are advertised, marketed, offered or designed primarily to provide coverage for not less than twelve (12) consecutive months for each covered person on an expense incurred, indemnity, prepaid, or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital.
- b. This term includes group and individual health policies or riders or group and individual life policies or annuities or riders which provide, directly or as a supplement, coverage for long-term care, whether issued by insurers, fraternal benefit societies, nonprofit health, hospital, and medical service corporations, prepaid health plans, health maintenance organizations, life care communities, or any similar organization.
- c. This term also includes a policy or rider which provides for payment of long-term care benefits based upon cognitive impairment or the loss of functional capacity.
- d. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage or related asset-protection coverage, catastrophic coverage, comprehensive coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

- e. With regard to life insurance, this term does not include life insurance policies which accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement, and which provide the option of a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.
- f. Notwithstanding any other provision contained herein, any product advertised, marketed or offered as long-term care insurance shall be subject to the provisions of the Long-Term Care Act.

2. "Applicant" means:

- a. in the case of an individual long-term care insurance policy, the person who seeks to contract for such benefits, and
- b. in the case of a group long-term care insurance policy, the proposed certificate holder.

3. "Certificate" means any certificate issued under a group long-term care insurance policy, which certificate has been delivered, or issued for delivery, in this state.

4. "Group long-term care insurance" means a long-term care insurance policy which is delivered, or issued for delivery, in this state and issued to:

- a. one or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees, or a combination thereof or for members or former members, or a combination thereof, of the labor organizations, or
- b. any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association:
 - (1) is composed of individuals, all of whom are or were actively engaged in the same profession, trade or occupation, and
 - (2) has been maintained in good faith for purposes other than insurance, or
- c. an association, a trust, or the trustee or trustees of a fund established, created, or maintained for the benefit of members of one or more associations. Prior to advertising, marketing or offering such policy within this state, the association or associations, or the insurer of the association or associations, shall

file evidence with the Insurance Commissioner that the association or associations shall have at the outset of transacting long-term care insurance in this state a minimum of one hundred (100) persons in the association or associations and shall have been organized and maintained in good faith for purposes other than that of obtaining insurance; shall have been in active existence for at least one (1) year; and shall have a constitution and bylaws which provide that (i) the association or associations hold regular meetings not less than annually to further purposes of the members, (ii) except for credit unions, the association or associations collect dues or solicit contributions from members, and (iii) the members have voting privileges and representation on the governing board and committees. Thirty (30) days after such filing the association or associations shall be deemed to satisfy such organizational requirements, unless the Commissioner makes a finding that the association or associations do not satisfy those organizational requirements, or

- d. a group other than as described in subparagraphs a, b and c of this paragraph, subject to a finding by the Commissioner that:
 - (1) the issuance of the group policy is not contrary to the best interest of the public,
 - (2) the issuance of the group policy would result in economies of acquisition or administration, and
 - (3) the benefits are reasonable in relation to the premiums charged.

5. "Not-for-Profit Life care community" within the meaning of Section 1-853.1 of Title 63 of the Oklahoma Statutes means any not-for-profit organization that enters into an arrangement pursuant to which a person contracts for a place of residence and personal care services, including but not limited to services which progress from independent living to semi-dependent nursing care to acute nursing care, in consideration of an endowed prepayment, license or entry fee which has been actuarially established to meet the cost of the promised services and accommodations. For communities commencing operations after January 1, 2016, the amount of the endowed prepayment must be independently, actuarially determined, in compliance with the Actuarial Standards of Practice promulgated by the Actuarial Standards Board of the American Academy of Actuaries, prior to opening the community and annually thereafter to ensure that sufficient payments are collected to meet the future services of the residents. The actuarial study shall take into consideration projected or actual project costs, resident fees and charges,

resident contract provisions and any other factors affecting the operation of the facility. It shall contain mortality and morbidity data and an actuary's signed opinion that the proposed is feasible and that the study has been prepared in accordance with standards adopted by the American Academy of Actuaries. A not-for-profit life care community shall not include the following:

- a. traditional landlord and tenant agreements utilizing periodic rental and security deposit payments,
- b. residential care homes licensed pursuant to the Oklahoma Residential Care Act,
- c. assisted living centers and continuum of care facilities licensed pursuant to the Oklahoma Continuum of Care and Assisted Living Act,
- d. facilities licensed pursuant to the Oklahoma Nursing Home Care Act, or
- e. any facility where the endowed prepayment, license or entry fee is less than Fifty Thousand Dollars (\$50,000.00).

6. "Policy" means any policy, contract, certificate, subscriber agreement, rider or endorsement delivered, or issued for delivery, in this state by an insurer, fraternal benefit society, nonprofit health, hospital, or medical service corporation, prepaid health plan, health maintenance organization, life care community, or any similar organization.

7. "Qualified long-term care insurance contract" means any:

- a. individual or group insurance contract if the contract meets the requirements of Section 7702(B) of the Internal Revenue Code, as amended, and if:
 - (1) the only insurance protection provided under the contract is coverage of qualified long-term care services,
 - (2) the contract does not pay or reimburse expenses incurred for services or items to the extent that such expenses are reimbursable under Title XVIII of the Social Security Act as amended, or would be so reimbursable but for the application of a deductible or coinsurance amount. The requirements of this subparagraph do not apply to contracts where Medicare is a secondary payor, or where the contract makes per diem or other periodic payments without regard to expenses,
 - (3) the contract is guaranteed renewable,
 - (4) the contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed. All refunds of premiums and all policyholder dividends or similar amounts, under

such contract are to be applied as a reduction in future premiums or to increase future benefits, except that a refund of the aggregate premium paid under the contract may be allowed in the event of death of the insured or a complete surrender or cancellation of the contract, and

- (5) the contract contains the consumer protection provisions set forth in Section 7702(B)(g) of the Internal Revenue Code, or
- b. life insurance contract which provides long-term care coverage by rider or as part of the contract if the contract complies with the applicable provisions of Section 7702(B) of the Internal Revenue Code, as amended.

8. "Qualified long-term care services" means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance for personal care services for which an insured is eligible under a qualified long-term care insurance contract, and which are provided pursuant to a plan of care prescribed by a licensed health care practitioner. Added by Laws 1987, c. 175, § 28, eff. Nov. 1, 1987. Amended by Laws 1989, c. 107, § 3, eff. Nov. 1, 1989; Laws 1989, c. 320, § 5, eff. Nov. 1, 1989; Laws 1993, c. 136, § 1, eff. Sept. 1, 1993; Laws 1997, c. 180, § 1, emerg. eff. May 12, 1997; Laws 2000, c. 171, § 2, emerg. eff. May 2, 2000; Laws 2008, c. 184, § 19, eff. July 1, 2008; Laws 2016, c. 264, § 1, eff. Nov. 1, 2016; Laws 2018, c. 95, § 9, eff. Nov. 1, 2018.

§36-4425. Repealed by Laws 1993, c. 136, § 5, eff. Sept. 1, 1993.

§36-4426. Requirements of policies.

A. No long-term care insurance policy shall:

1. Be canceled, nonrenewed, or otherwise terminated on the grounds of age or the deterioration of the mental or physical health of the insured individual or certificate holder;

2. Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or

3. Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.

B. 1. No long-term care insurance policy or certificate shall use a definition of "preexisting condition" which is more restrictive than the following: Preexisting condition means a condition for which medical advice or treatment was recommended by,

or received from a provider of health care services, within six (6) months preceding the effective date of coverage of an insured person.

2. No long-term care insurance policy or certificate shall exclude coverage for a loss or confinement which is the result of a preexisting condition unless such loss or confinement begins within six (6) months following the effective date of coverage of an insured person.

3. The definition of "preexisting condition" does not prohibit an insurer:

- a. from using an application form designed to elicit the complete health history of an applicant, and
- b. from underwriting, on the basis of the answers on that application, in accordance with that insurer's established underwriting standards.

4. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in paragraph 2 of subsection B of this section expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in paragraph 2 of subsection B of this section.

C. Prior hospitalization/institutionalization:

1. No long-term care insurance policy may be delivered or issued in this state if such policy:

- a. conditions eligibility for any benefits on a prior hospitalization requirement,
- b. conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care, or
- c. conditions eligibility for any benefits other than waiver of premium, post-confinement, post-acute care or recuperative benefits on a prior institutionalization requirement.

2.
 - a. A long-term care insurance policy containing post-confinement, post-acute care or recuperative benefits shall clearly label in a separate paragraph of the policy or certificate entitled "Limitations or Conditions on Eligibility for Benefits" such limitations or conditions, including any required number of days of confinement.
 - b. A long-term care insurance policy or rider which conditions eligibility of noninstitutional benefits on the prior receipt of institutional care shall not

require a prior institutional stay of more than thirty (30) days.

D. No law, rule or regulation shall establish loss ratio standards for long-term care insurance policies unless a specific reference to long-term care insurance policies is contained in such law, rule or regulation.

E. Long-term care insurance applicants shall have the right to return the policy or certificate within thirty (30) days after its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied with the policy, for any reason. Long-term care insurance policies and certificates shall have a notice prominently printed on the first page of the policy or attached thereto, stating in substance, that the applicant shall have the right to return the policy or certificate within thirty (30) days after its delivery and to have the premium refunded if, after examination of the policy, or certificate, the applicant is not satisfied with the policy, for any reason. If an application for a qualified long-term care contract is denied, the issuer shall refund to the applicant any premium and any other fees submitted by the applicant within thirty (30) days of the date of the denial. If the insurer does not return any premiums or moneys paid therefor within thirty (30) days from the date of cancellation, the insurer shall pay interest on the proceeds which shall be the same rate of interest as the average United States Treasury Bill rate of the preceding calendar year, as certified to the Insurance Commissioner by the State Treasurer on the first regular business day in January of each year, plus two (2) percentage points, which shall accrue from the date of cancellation until the premiums or moneys are returned. In such event, the long-term care policy shall be deemed to have been canceled on the date the policy was placed in the United States mail in a properly addressed, postpaid envelope, or, if not so posted, on the date of delivery of such policy or annuity to the insurer.

F. An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means which prominently direct the attention of the recipient to the document and its purpose. The Insurance Commissioner shall prescribe a standard format, including style, arrangement and overall appearance, and the content of an outline of coverage. In the case of agent solicitations, an agent must deliver the outline of coverage prior to the presentation of an application or enrollment form. In the case of direct response solicitations, the outline of coverage must be presented in conjunction with any application or enrollment form. Such outline of coverage shall include, but not be limited to:

1. A description of the principal benefits and coverage provided in the policy;

2. A statement of the principal exclusions, reductions and limitations contained in the policy;

3. A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premiums. Continuation or conversion provisions of group coverage shall be specifically described;

4. A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;

5. A description of the terms under which the policy or certificate may be returned and premium refunded;

6. A brief description of the relationship of cost of care and benefits; and

7. If the policy or certificate is intended to be a qualified long-term care insurance contract, a statement that discloses to the policyholder or certificate holder that the policy is intended to be a qualified long-term care insurance contract.

G. The issuer of a qualified long-term care insurance contract shall deliver to the applicant, policyholder, or certificate holder the contract or certificate no later than thirty (30) days after the date of approval.

H. At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy which provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make such delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary shall also include:

1. An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;

2. An illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits if any, for each covered person;

3. Any exclusions, reductions and limitations on benefits of long-term care; and

4. If applicable to the policy type, the summary shall also include:

- a. a disclosure of the effects of exercising other rights under the policy,
- b. a disclosure of guarantees related to long-term care costs of insurance charges, and
- c. current and projected maximum lifetime benefit.

I. Any time a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in

benefit payment status, a monthly report shall be provided to the policyholder. Such report shall include:

1. Any long-term care benefits paid out during the month;
2. An explanation of any changes in the policy, e.g. death benefits or cash values, due to long-term care benefits being paid out; and
3. The amount of long-term care benefits existing or remaining.

J. If a claim under a qualified long-term care insurance contract is denied, the issuer shall, within sixty (60) days of the date of a written request by the policyholder or certificate holder, or a representative thereof:

1. Provide a written explanation of the reasons for the denial; and
2. Make available all information directly related to such denial.

K. No policy shall be advertised, marketed or offered as long-term care insurance unless it complies with the provisions of the Long-Term Care Insurance Act.

L. Policies or contracts issued by life care communities which are not licensed insurers in this state shall contain the following statement in conspicuous bold-face type on the front of the policy or contract: "The financial condition of the entity issuing this contract is not subject to review by or the jurisdiction of the Oklahoma Insurance Commissioner. This contract is not subject to the protection of any guaranty association."

Added by Laws 1987, c. 175, § 30, eff. Nov. 1, 1987. Amended by Laws 1989, c. 107, § 4, eff. Nov. 1, 1989; Laws 1993, c. 136, § 2, eff. Sept. 1, 1993; Laws 1994, c. 294, § 8, eff. Sept. 1, 1994; Laws 1997, c. 180, § 2, emerg. eff. May 12, 1997.

§36-4426.1. Rescission or denial of claim upon grounds of misrepresentation.

A. For a policy or certificate that has been in force for less than six (6) months, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is material to the acceptance for coverage.

B. For a policy or certificate that has been in force for at least six (6) months but less than two (2) years, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is both material to the acceptance for coverage and which pertains to the conditions for which benefits are sought.

C. After a policy or certificate has been in force for two (2) years, it is not contestable upon the grounds of misrepresentation alone; such policy or certificate may be contested only upon a

showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.

D. 1. No long-term care insurance policy or certificate may be field-issued based on medical or health status.

2. For purposes of this section, "field-issued" means a policy or certificate issued by an agent or a third-party administrator pursuant to the underwriting authority granted to the agent or third-party administrator by an insurer.

E. If an insurer has paid benefits under the long-term care insurance policy or certificate, the benefit payments may not be recovered by the insurer in the event that the policy or certificate is rescinded.

F. Provided further, if under the provisions of this section said policy or certificate is rescinded by the insurer, then in that event the insured shall be refunded within thirty (30) days of rescission all premiums paid to the insurer by the insured for the policy or certificate.

Added by Laws 1993, c. 136, § 3, eff. Sept. 1, 1993.

§36-4426.2. Nonforfeiture benefits.

A. 1. No insurer may offer a long-term care insurance policy unless the insurer also offers to the applicant the option to purchase a policy that provides for nonforfeiture benefits.

2. This section shall not apply to life insurance policies or riders containing accelerated long-term care benefits.

3. For certificates issued on or after the effective date of this act, under a group long-term care insurance policy as defined in Section 4424 of Title 36 of the Oklahoma Statutes, which policy was in force at the time this act became effective, the provisions of this section shall not apply.

B. The Insurance Commissioner shall promulgate rules which are consistent with the National Association of Insurance Commissioners (NAIC) Long-Term Care Model Regulation and which specify the types of nonforfeiture benefits to be included in policies and certificates, the standards for the benefits, and the date nonforfeiture benefits must commence.

C. 1. For purposes of this section, the nonforfeiture benefit shall be a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefit amounts and frequency in effect at the time of lapse, but not increased thereafter, shall be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in paragraph 3 of this subsection.

2. Nonforfeiture benefits for qualified long-term care insurance contracts shall include at least a reduced paid-up insurance benefit, an extended term insurance benefit, the offer of a shortened benefit period, or other similar offerings approved by

the Insurance Commissioner, and shall be provided as specified in regulations. The issuer of such a contract may refund premiums upon the death of the insured or upon complete surrender or cancellation of the contract or policy, as long as the refund does not exceed the aggregate premiums paid for the contract or policy.

3. The standard nonforfeiture credit shall be equal to one hundred percent (100%) of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However for lapses occurring at the end of the third policy year and thereafter, the minimum nonforfeiture credit shall not be less than thirty (30) times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation set forth in subsection D of this section.

4. Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

5. There shall be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.

D. All benefits paid by the insurer while the policy or certificate is in premium paying status and in paid-up status shall not exceed the maximum benefits which would have been payable if the policy or certificate had remained in premium paying status. Added by Laws 1995, c. 244, § 2, eff. Nov. 1, 1995. Amended by Laws 1997, c. 180, § 3, emerg. eff. May 12, 1997.

§36-4427. Rulemaking authority - Civil penalty.

A. The Insurance Commissioner may adopt rules to implement the provisions of the Long-Term Care Insurance Act. The Commissioner may adopt rules that apply to all providers of long-term care insurance coverage, whether or not a provider is otherwise subject to the provisions of the Insurance Code, and that include, but are not limited to, standards for full and fair disclosure setting forth the manner, content, and required disclosure for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, and definition of terms. The Commissioner may issue reasonable rules to establish minimum standards for marketing practices, agent compensation, agent

testing, penalties and reporting practices for long-term care insurance.

B. In addition to any other penalties provided by the laws of this state, any insurer and any agent found to have violated any requirement of this state relating to the regulation of long-term care insurance or the marketing of such insurance shall be subject to a civil penalty of up to three (3) times the amount of any commissions paid for each policy involved in the violation or up to Ten Thousand Dollars (\$10,000.00) whichever is greater.

Added by Laws 1987, c. 175, § 31, eff. Nov. 1, 1987. Amended by Laws 1989, c. 107, § 5, eff. Nov. 1, 1989; Laws 1993, c. 136, § 4, eff. Sept. 1, 1993; Laws 1997, c. 418, § 97, eff. Nov. 1, 1997.

§36-4428. Investment of life care community policy funds.

Any funds received pursuant to a life care community policy shall be invested only in assets enumerated in Section 1607 of Title 36 of the Oklahoma Statutes.

Added by Laws 1989, c. 107, § 6, eff. Nov. 1, 1989.

§36-4429. Suitability standards.

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

2. For certificates issued on or after the effective date of this act, under a group long-term care insurance policy as defined in Section 4424 of Title 36 of the Oklahoma Statutes, which policy was in force at the time this act became effective, the provisions of this section shall not apply.

B. Every provider of long-term care insurance shall:

1. Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;

2. Train its agents in the use of its suitability standards; and

3. Maintain a copy of its suitability standards and make them available for inspection upon request by the Insurance Commissioner.

C. 1. To determine whether the applicant meets the standards developed by the provider, the agent and provider shall develop procedures that take the following into consideration:

a. the ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage,

b. the applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs, and

c. the values, benefits and costs of the applicant's existing insurance, if any, when compared to the

values, benefits and costs of the recommended purchase or replacement.

2. The provider and, where an agent is involved, the agent shall make reasonable efforts to obtain the information set out in paragraph 1 of this subsection. The efforts shall include, at or prior to application, providing the applicant with a personal worksheet and a disclosure form which have been prescribed by the Commissioner and are consistent with the National Association of Insurance Commissioners (NAIC) Long-Term Care Insurance Model Regulation.

3. A completed personal worksheet shall be returned to the provider prior to the provider's consideration of the applicant for coverage, except that the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.

4. The sale or dissemination outside the company or agency by the provider or agent of information obtained through the personal worksheet is prohibited.

D. The provider shall use the suitability standards it has developed pursuant to this section and information furnished by the applicant in determining whether issuing long-term care insurance coverage to an applicant is appropriate.

Added by Laws 1995, c. 244, § 3, eff. Nov. 1, 1995.

§36-4430. Renewal premium rates.

A. Upon approval of the Insurance Commissioner, an insurer may charge an increased renewal premium upon showing that the 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.

Added by Laws 1995, c. 244, § 4, eff. Nov. 1, 1995. Amended by Laws 2001, c. 363, § 21, eff. July 1, 2001; Laws 2002, c. 307, § 31, eff. Nov. 1, 2002; Laws 2009, c. 176, § 32, eff. Nov. 1, 2009.

§36-4501. Eligible groups.

Group accident and health insurance is hereby declared to be that form of accident and health insurance covering groups of persons as defined below, with or without one or more members of their families or one or more of their dependents, or covering one

or more members of the families or one or more dependents of persons in such groups, and issued upon the following basis:

1. Under a policy issued to an association, which has been in existence for at least twelve (12) months, including a labor union, which shall have a constitution and bylaws and which has been organized and is maintained in good faith for purposes other than that of obtaining insurance, insuring at least ten members, employees, or employees of members of the association for the benefit of persons other than the association or its officers or trustees. The term "employees" as used herein shall be deemed to include retired employees;

2. Under a policy issued to the trustees of a fund established by two or more employers or by one or more labor unions or by one or more employers and one or more labor unions, which trustees shall be deemed the policyholder, to insure employees of the employers or members of the unions for the benefit of persons other than the employers or the unions. The term "employees" as used herein shall be deemed to include the officers, managers and employees of the employer, and the individual proprietor or partners if the employer is an individual proprietor or partnership. The term "employees" as used herein shall be deemed to include retired employees. The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship;

3. Under a policy issued to any persons or organizations to which a policy of group life insurance may be delivered in this state, to insure any class or classes of individuals that could be insured under such group life policy;

4. Under a health insurance policy issued to an employer or trustees of a fund established by an employer, who shall be deemed the policyholder insuring at least one employee of such employer for the benefit of persons other than the employer. The term "employee" as used herein shall be deemed to include the officers, managers, and employees of the employer, the individual proprietor or partners if the employer is an individual proprietor or partnership, the officers, managers, and employees of subsidiary or affiliated corporations, the individual proprietors, partners and employees of individuals and firms, if the business of the employer and such individual or firm is under common control through stock ownership, contract, or otherwise. The term "employee" as used herein shall be deemed to include retired employees and their dependents and the dependents of employees eligible for Medicare. A policy issued to insure employees of a public body may provide that the term "employees" shall include elected or appointed officials;

5. Under a policy issued to cover any other substantially similar group which, in the discretion of the Insurance

Commissioner, may be subject to the issuance of a group accident and health policy or contract; and

6. Nothing in this article validates any charge or practice illegal under any rule of law or regulation governing usury, small loans, retail installment sales, or the like, or extends the application of any such rule of law or regulation to any transaction not otherwise subject thereto.

Added by Laws 1957, p. 398, § 4501. Amended by Laws 1990, c. 114, § 1, eff. Sept. 1, 1990; Laws 1992, c. 304, § 1, eff. Jan. 1, 1993; Laws 1994, c. 294, § 9, eff. Sept. 1, 1994; Laws 2008, c. 184, § 20, eff. July 1, 2008.

§36-4502. Provisions of group accident and health policies.

A. Each group accident and health policy shall contain in substance the following provisions:

1. A provision that, in the absence of fraud, all statements made by the policyholder or by any insured person shall be deemed representations and not warranties, and that no statement made for the purpose of effecting insurance shall avoid such insurance or reduce benefits unless contained in a written instrument signed by the policyholder or the insured person, a copy of which has been furnished to such policyholder or to such person or his or her beneficiary;

2. A provision that the insurer will furnish to the policyholder, for delivery to each employee or member of the insured group, an individual certificate setting forth in summary form a statement of the essential features of the insurance coverage of such employee or member and to whom benefits are payable. If dependents or family members are included in the coverage additional certificates need not be issued for delivery to such dependents or family members; and

3. A provision that to the group originally insured may be added from time to time eligible new employees or members or dependents, as the case may be, in accordance with the terms of the policy.

B. Each group health policy certificate subject to the provisions of the Federal Health Insurance Portability and Accountability Act, Public Law 104-191, (HIPAA) laws shall contain in substance the following provisions, which shall be in addition to the provisions required by subsection A of this section.

1. A provision that a health benefit plan shall not deny, exclude or limit benefits for a covered individual for losses incurred more than twelve (12) months following the effective date of the individual's coverage due to a preexisting condition;

2. A provision that a health benefit plan shall not define a preexisting condition more restrictively than:

- a. a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage,
- b. pregnancy and genetic information shall not be considered preexisting conditions,
- c. a health benefit plan may exclude a preexisting condition for late enrollees for a period not to exceed eighteen (18) months from the date the individual enrolls for coverage,
- d. the period of any such preexisting condition exclusion shall be reduced by the aggregate of the periods of creditable coverage as defined in the Federal HIPAA laws,
- e. a period of creditable coverage shall not be counted if after such period and before the enrollment date, there was a sixty-three-day period during all of which the individual was not covered under any creditable coverage,
- f. "enrollment date" means the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment, and
- g. "late enrollee" means a participant or beneficiary who enrolls under the plan other than during the first period in which the individual is eligible to enroll under the plan or a special enrollment period;

3. A provision that individuals losing other coverage shall be permitted to enroll for coverage under the terms of the plan if each of the following conditions is met:

- a. the employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent,
- b. the employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or issuer required such a statement at such time and provided the employee with notice of such requirement, and the consequences of such requirement, at such time,
- c. the employee's or dependent's coverage was under a COBRA continuation provision and the coverage under such provision was exhausted; or was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage, including as a result of legal separation, divorce,

death, termination of employment, or reduction in the number of hours of employment, or employer contributions toward such coverage were terminated, and

- d. under the terms of the plan, the employee requests such enrollment not later than thirty (30) days after the date of exhaustion of coverage;

4. A provision that for any period that an individual is in a waiting period for any coverage under a group health plan or for group health insurance coverage or is in an affiliation period, that period shall not be taken into account in determining the continuous period of creditable coverage. "Affiliation period" means a period which, under the terms of the health insurance coverage offered by a health maintenance organization, must expire before the health insurance coverage becomes effective. The organization is not required to provide health care services or benefits during such period and no premium shall be charged to the participant or beneficiary for any coverage during the period;

5. A provision that preexisting condition exclusions will not apply to newborns, who, as the last day of the thirty-day period beginning with the date of birth, are covered under creditable coverage;

6. A provision that preexisting condition exclusions will not apply to a child who is adopted or placed for adoption before attaining eighteen (18) years of age;

7. A provision that dependents are eligible for a special enrollment period if the group health plan makes coverage available with respect to a dependent of an individual, and the individual is a participant under the plan, or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period, and a person becomes such a dependent of the individual through marriage, birth or adoption or placement for adoption. The special enrollment period shall apply to that person or, if not otherwise enrolled, the individual, the dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

- a. The dependent special enrollment period shall be a period of not less than thirty (30) days and shall begin on the later of the date dependent coverage is made available, or the date of the marriage, birth, or adoption or placement for adoption.
- b. There is no waiting period if an individual seeks to enroll a dependent during the first thirty (30) days of such a dependent special enrollment period.

- c. The coverage for the dependent shall become effective in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received, in the case of a dependent's birth, as of the date of such birth, in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption;

8. A provision that eligibility or continued eligibility of any individual will not be based on any of the following health-status-related factors in relation to the individual or a dependent of the individual: health status, medical condition, including both physical and mental illnesses, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, including conditions arising out of acts of domestic violence or disability.

- a. Carriers are not required to provide particular benefits other than those provided under the terms of the plan or coverage.
- b. Carriers may establish limitations or restrictions on the amount, level, extent, and nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage; and

9. A provision that the group health plan is guaranteed renewable, except as provided pursuant to the federal provisions found in HIPAA, which are as follows:

- a. nonpayment of premium,
- b. fraud,
- c. violation of participation and/or contribution rules,
- d. termination of coverage:

- (1) in any case in which an issuer decides to discontinue offering a particular type of group health insurance coverage offered in the large or small group market, coverage of such type may be discontinued by the issuer only if: the issuer provides notice to each plan sponsor provided coverage of this type in such market, and participants and beneficiaries covered under such coverage, of such discontinuation at least ninety (90) days prior to the date of the discontinuation of such coverage and makes available the option to purchase all or, in the case of the large group market, any other health insurance coverage currently being offered by the issuer to a group health plan in such market and in exercising the option to discontinue coverage of this type and in offering the option of

coverage pursuant to this provision, the issuer acts uniformly without regard to the claims experience of those sponsors or any health-status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage,

- (2) in any case in which an issuer decides to discontinue offering a particular type of group health insurance coverage offered in the large or small group market, coverage of such type may be discontinued by the issuer only if: the issuer provides notice to the Oklahoma Insurance Department and to each plan sponsor and participants and beneficiaries covered under such coverage of such discontinuation at least one hundred eighty (180) days prior to the date of the discontinuation of such coverage; and all health insurance issued or delivered for issuance in the state in such market or markets are discontinued and coverage under such health insurance coverage in such market or markets is not renewed, and
- (3) in the case of a discontinuation under division (2) of this subparagraph in a market, the issuer shall not provide for the issuance of any health insurance coverage in the market and in this state during the five-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed,
 - e. movement outside the service area, and
 - f. association membership ceases.

Added by Laws 1957, p. 399, § 4502. Amended by Laws 2001, c. 363, § 22, eff. July 1, 2001; Laws 2015, c. 298, § 11, eff. Nov. 1, 2015.

§36-4502.1. Conversion privilege.

A. A health insurance policy delivered or issued for delivery in this state that provides for conversion to an individual policy by an insured on termination of membership in or employment with the group shall provide a conversion privilege to an individual policy to the spouse of the insured on death of the insured or on divorce from the insured or on termination of the insured's membership in or employment with the group for any reason including retirement. If the conversion privilege available to the insured provides for coverage of the insured's spouse, the group insurer shall not be required to issue a separate conversion policy to the spouse.

B. Subsection A of this section applies only to a spouse of an insured if the spouse is covered under the health insurance policy at the time of the insured's death or divorce from the insured or termination of the insured's coverage.

C. This act applies to all health insurance policies that are delivered or issued for delivery in this state on or after October 1, 1981. Any presently approved policy forms containing any provision in conflict with the requirements of this act may be brought into compliance with this act by the use of riders and endorsements which have been approved by the Commissioner of Insurance.

D. As used in this section:

1. "Health insurance policy" means a group policy or contract providing insurance for hospital, surgical, or medical expenses incurred as a result of an accident or sickness.

2. "Insured" means an employee or member of a group that is covered by a health insurance policy.

E. The person who accepts the conversion policy shall become the insured and pay the premiums direct to the insurer.

Laws 1981, c. 160, § 2.

§36-4503. Direct payment of hospital, medical services.

Any group accident and health policy may provide that subject to any written direction of the insured in the application or otherwise, all or any portion of any indemnities provided by any such policy on account of hospital, nursing, medical or surgical services may, at the insurer's option, and unless the insured requests otherwise not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but the policy may not require that the service be rendered by a particular hospital or person. Payments so made shall discharge the insurer's obligation with respect to the amount of insurance so paid.

Laws 1957, p. 399, § 4503.

§36-4504. Blanket accident and health insurance.

A. Blanket accident and health insurance is hereby declared to be that form of accident and health insurance covering special groups of persons as enumerated in one of the following paragraphs (1) to (7) inclusive:

1. Under a policy or contract issued to any common carrier, which shall be deemed the policyholder, covering a group defined as all persons who may become passengers on such common carrier.

2. Under a policy or contract issued to an employer, who shall be deemed the policyholder, covering all employees or any group of employees defined by reference to exceptional hazards incident to

such employment. Dependents of the employees and guests of the employer may also be included where exposed to the same hazards.

3. Under a policy or contract issued to a college, school, or other institution of learning or to the head or principal thereof, who or which shall be deemed the policyholder, covering students or teachers.

4. Under a policy or contract issued in the name of any volunteer fire department, first aid, or other such volunteer group, or agency having jurisdiction thereof, which shall be deemed the policyholder, covering all of the members of such fire department or group.

5. Under a policy or contract issued to a creditor, who shall be deemed the policyholder, to insure debtors of the creditor.

6. Under a policy or contract issued to a sports team or to a camp or sponsor thereof, which shall be deemed the policyholder, covering members or campers.

7. Under a policy or contract issued to any other substantially similar group which, in the discretion of the Insurance Commissioner, may be subject to the issuance of a blanket accident and health policy or contract.

B. An individual application need not be required from a person covered under a blanket accident and health policy or contract, nor shall it be necessary for the insurer to furnish each person a certificate.

C. All benefits under any blanket accident and health policy shall be payable to the person insured, or to his designated beneficiary or beneficiaries, or to his estate, except that if the person insured be a minor, such benefits may be made payable to his parent, guardian, or other person actually supporting him; except, that the policy may provide that subject to any written direction of the insured in the application or otherwise, all or any portion of any indemnities provided by any such policy on account of hospital, nursing, medical or surgical services may, at the insurer's option and unless the insured requests otherwise not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services, but the policy may not require that the service be rendered by a particular hospital or person. Payments so made shall discharge the insurer's obligation with respect to the amount of insurance so paid.

D. Nothing contained in this section shall be deemed to affect the legal liability of policyholders for the death of or injury to any such member of such group.

Laws 1957, p. 399, § 4504.

§36-4505. Group and blanket accident and health policy provisions.

The provisions of Article 44 (Individual Accident and Health Insurance) shall not apply to group accident and health or blanket

accident and health insurance policies, but no such policy of group or blanket accident and health insurance shall contain any provision relative to notice or proof of loss, or to the time for paying benefits, or to the time within which suit may be brought on the policy, which is less favorable to the individuals insured than would be permitted by the standard provisions required for individual accident and health insurance policies.
Laws 1957, p. 400, § 4505.

§36-4506. Misrepresentation prohibited.

No insurance company, authorized to issue accident and health contracts in this state, and no officer, director, agent, employee, solicitor, or other representative thereof, or any other person, shall make, issue, circulate or cause or permit to be made, issued or circulated, any estimate, illustration, circular or statement of any sort misrepresenting the terms, conditions or character of any policy issued by it or the benefits or advantages promised thereby, or shall use any name or title on any policy or class of policies misrepresenting the true nature thereof.
Laws 1957, p. 400, § 4506.

§36-4507. Rules and regulations.

The Insurance Commissioner may make and promulgate written rules and regulations reasonable, necessary and incidental to the enforcement and administration of the provisions of this article.
Laws 1957, p. 400, § 4507.

§36-4508. Selection of licensed psychologist or licensed and certified clinical social worker - Definitions.

A. If the terms of any group or blanket accident and health insurance policy cover services within the lawful scope of practice of a licensed psychologist or licensed and certified clinical social worker then:

1. Such services may be performed by any person licensed to do so in this state as provided in subsection B of this section.

2. Selection of such a psychologist or social worker may be made by the insured at his option and, provided other conditions of the policy are met, reimbursement shall not be denied when service is rendered by a person so licensed.

3. The provisions of this section shall apply to the policies and contracts of insurance issued thereunder which are delivered, amended, ratified, or issued for delivery in Oklahoma, after October 1, 1982.

4. Any provision, exclusion, or limitation of a policy that denies an insured the privilege of selecting such a psychologist or social worker shall, to the extent of the denial, be void, but such

void provision shall not affect the validity of the other provisions of the policy.

B. For purposes of this section:

1. "Licensed psychologist" means a person licensed and complying with the Psychologists Licensing Act, Sections 1351 through 1375 of Title 59 of the Oklahoma Statutes; and

2. "Licensed and certified social worker" means a person licensed and complying with the Social Workers' Licensing Act, Sections 1250.1 (3) and 1261.1 (B) of Title 59 of the Oklahoma Statutes.

Amended by Laws 1982, c. 61, § 3, operative Oct. 1, 1982.

§36-4509. Extension and termination of coverage under group accident and health policy and contracts of hospital or medical service or indemnity.

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 for any reason other than termination of the group plan or termination for gross misconduct 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 the dependents of the employee shall be offered continuation of coverage under the group policy or contract for a period of at least sixty-three (63) days after such termination. The carrier shall notify the terminated employee of the availability of this continuation of coverage option in writing within thirty (30) days of receiving notice from the plan sponsor of the employee's termination of coverage. The terminated employee shall request in writing the continuation of group coverage not later than the thirty-first day after the date the terminated employee is given notification of the availability of this continuation of coverage option. Premiums may be charged for the continuation of coverage 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. Continuation of coverage pursuant to this section may be terminated:

1. For employee's failure to make timely premium payments;

2. On the date the group coverage terminates in its entirety if the group coverage terminates in its entirety during the continuation of coverage period; or

3. If the employee and the dependents of the employee otherwise become entitled to similar insurance from some other source during the continuation of the coverage period.

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.

Added by Laws 1975, c. 110, § 1, eff. Jan. 1, 1976. Amended by Laws 1985, c. 328, § 20, emerg. eff. July 29, 1985; Laws 1986, c. 251, § 42, eff. Nov. 1, 1986; Laws 1988, c. 18, § 1, eff. Nov. 1, 1988; Laws 2009, c. 207, § 1, emerg. eff. May 18, 2009; Laws 2012, c. 44, § 12, eff. Nov. 1, 2012.

NOTE: Laws 2009, c. 176, § 33 repealed by Laws 2010, c. 2, § 12, emerg. eff. March 3, 2010.

§36-4509.1. Liability of prior carrier - Eligibility under succeeding carrier - Determination of benefits - Election of coverage.

A. This section applies to determination of the liability of a carrier pursuant to a group or blanket accident or health insurance plan in those instances in which the contract of one carrier replaces a plan of similar benefits of another carrier. As used in this section, "carrier" means an insurer or other entity subject to the provisions of Title 36 of the Oklahoma Statutes, and includes but is not limited to a not-for-profit hospital service and medical indemnity corporation, a fraternal benefit society, a health maintenance organization and a multiple employer welfare arrangement.

B. The prior carrier shall be liable only to the extent of its accrued liabilities and extensions of benefits. The position of the prior carrier shall be the same whether the group policyholder or other entity responsible for making payments or submitting subscription charges to the carrier secures replacement coverage from a new carrier, self-insures, or foregoes the provision of coverage.

C. Each person who was covered by the plan of the prior carrier shall be covered by the plan of benefits of the succeeding carrier conditioned only upon the payment of the premium.

D. The succeeding carrier, in applying any deductibles or waiting periods in its plan, including but not limited to waiting periods for preexisting conditions, shall give credit for the satisfaction or partial satisfaction of the same or similar provisions under a prior plan providing similar benefits and shall not impose any additional waiting periods for coverage for any person who was covered by the plan of the prior carrier. In the case of deductible provisions, the credit shall apply for the same or overlapping benefit periods and shall be given for expenses actually incurred and applied against the deductible provisions of the prior plan during the ninety (90) days preceding the effective date of the succeeding plan but only to the extent these expenses are recognized under the terms of the plan of the succeeding carrier and are subject to similar deductible provision.

E. If a determination of the benefits of the prior plan is required and requested by the succeeding carrier, upon receiving such request, the prior carrier shall furnish a statement of the benefits available or pertinent information sufficient either to permit verification of the benefits available under the prior plan or to permit the determination of the benefits by the succeeding carrier. For the purposes of this subsection, benefits of the prior plan shall be determined in accordance with all of the definitions, conditions, and covered expense provisions of the prior plan and shall not be subject to the definitions, conditions, and covered expense provisions of the succeeding plan. The benefit determination shall be made as if coverage had not been replaced by the succeeding carrier.

F. Nothing in this section shall prevent an individual from electing not to be covered under the plan of benefits of the succeeding carrier.

Added by Laws 1988, c. 123, § 1, eff. Nov. 1, 1988. Amended by Laws 1992, c. 304, § 2, eff. Jan. 1, 1993.

§36-4509.2. Acceptance by succeeding carriers - Preexisting conditions limitations or waiting requirements.

A. When an insured individual or a dependent who was covered by group insurance pursuant to the provisions of the Health Insurance

Portability and Accountability Act of 1996, 29 U.S.C.A., Section 1181 et seq., gains employment with an employer who provides for health insurance through a group plan, the succeeding group carrier shall accept the insured individual and dependents of the insured individual who were covered under the prior coverage and shall not apply limitations or exclusions based on preexisting conditions or apply waiting-period requirements for the insured individual or the dependents of the insured individual beyond the time when any surviving exclusion or waiting period with the prior carrier would have been fulfilled. The insured individual and any dependents of such individual must apply for the new coverage within sixty-three (63) days following the date of termination of prior creditable coverage.

B. When an insured individual or dependent who was covered by individual insurance pursuant to the provisions of the Health Insurance Portability and Accountability Act of 1996, 29 U.S.C.A., Section 1181 et seq., gains employment with an employer who provides for health insurance through a group plan, the succeeding group carrier shall accept the insured individual and dependents of the insured individual who were covered under the prior coverage and shall not apply limitations or exclusions based on preexisting conditions or apply waiting-period requirements for the insured individual or the dependents of the insured individual beyond the time when any surviving exclusion or waiting period with the prior carrier would have been fulfilled. The insured individual and any dependents of such individual must apply for the new coverage within sixty-three (63) days following the date of termination of prior creditable coverage.

C. Insurance carriers receiving an application for individual insurance may underwrite the risk or decline coverage based on the underwriting guidelines of the insurance carrier.

D. When there is a lapse in the coverage of the insured individual or a dependent of the insured individual provided for by subsections A, B, and C of this section for any reason other than a probationary period or similar waiting period imposed pursuant to personnel policies of an employer, the provisions of subsections A, B, and C of this section shall not apply to the person whose coverage lapsed.

E. When an individual employee who was covered under a group health insurance plan terminates employment with an employer and gains employment with another employer who provides for health insurance through a group plan, the carrier of the succeeding employer shall not apply preexisting conditions limitations or exclusions of preexisting conditions or apply waiting-period requirements for the individual employee or his dependents covered under the group plan of the previous employer beyond the time when any surviving exclusion or waiting period with the prior carrier

would have been fulfilled, provided the individual employee applies for the new coverage within thirty-one (31) days following the date of eligibility for participation in the plan in accordance with the employment or personnel policies of the employer of such participation.

F. When there is a lapse in the coverage of the individual employee provided for by subsection E of this section for any reason other than a probationary period or similar waiting period imposed by the employment or personnel policies of the employer, the provisions of subsection E of this section shall not apply.

Added by Laws 1992, c. 304, § 3, eff. Jan. 1, 1993. Amended by Laws 1993, c. 76, § 1, emerg. eff. April 18, 1993; Laws 1995, c. 224, § 1, eff. Nov. 1, 1995; Laws 1997, c. 180, § 4, emerg. eff. May 12, 1997; Laws 1998, c. 304, § 1, eff. July 1, 1998; Laws 2001, c. 363, § 23, eff. July 1, 2001; Laws 2014, c. 389, § 1, emerg. eff. June 3, 2014.

§36-4509.3. Rules.

The Insurance Commissioner shall adopt and promulgate rules for the provisions of Sections 4501 and 4509.1 of Title 36 of the Oklahoma Statutes and Section 3 of this act.

Added by Laws 1992, c. 304, § 4, eff. Jan. 1, 1993.

§36-4510. Repealed by Laws 1995, c. 356, § 4, eff. Nov. 1, 1995.

§36-4511. Employer health care programs - Pharmacy services - Violation.

A. No employer providing pharmacy services including prescription drugs to any employee or retiree of said employer, as part of a health care program, shall knowingly require the employee or retiree of said employer to obtain drugs from a mail order pharmacy as a condition of obtaining the employer's payment for such prescription drugs.

B. Any person violating the provisions of this section, upon conviction, shall be guilty of a misdemeanor. Each such violation shall constitute a separate offense.

Added by Laws 1987, c. 139, § 2, emerg. eff. June 19, 1987.

Renumbered from § 353.28 of Title 59 by Laws 1990, c. 127, § 1, eff. Sept. 1, 1990. Amended by Laws 2002, c. 307, § 32, eff. Nov. 1, 2002.

§36-4512. Insured employer health benefit plans - 20 or more employees.

A. This section applies to an insured employer health benefit plan providing health insurance to employees of employers employing twenty (20) or more full-time or full-time-equivalent employees.

B. An employer carrier, on written request from an insured employer covered by that carrier, shall report to the employer information from the twelve (12) months preceding the date of the report regarding:

1. The total amount of charges submitted to the carrier for persons covered under the employer health benefit plan;

2. The total amount of premium payments made by the policyholder to the insured carrier;

3. The total amount of payments made by the carrier to health care providers for persons covered under the plan, including the total hospital charges, physician charges, and pharmaceutical charges; and

4. For any claims for an individual paid in excess of Ten Thousand Dollars (\$10,000.00), information on claims paid, including diagnostic evaluations.

C. An employer shall have to make a written request for information. The employer may make one request per year prior to the anniversary or renewal date. In addition, prior to the date of a rate change, an employer may make additional written requests for the information, provided the employer shall not make more than one additional request in any one (1) year.

D. Except as otherwise provided in this subsection, an employer carrier shall provide the information provided for in this section not later than sixty (60) days before the anniversary or annual renewal date, or thirty (30) days before the date of any rate change action of the employer's benefit plan. Provided, if the carrier receives the request from the employer less than sixty (60) days before the anniversary or renewal date or less than thirty (30) days before the date of a rate change, the carrier shall have sixty (60) days from the date of receiving the request to provide the information. Provided further, if the carrier requires the employer to submit any changes to the benefit plan prior to the anniversary or annual renewal date, the carrier shall provide the information not later than sixty (60) days before the date the employer is required to submit any changes.

E. An employer carrier shall not report any information required under this section if the release of such information is prohibited by federal law or regulation.

F. Claim information provided by an employer carrier under this section shall be provided in the aggregate, without information through which a specific individual covered by the health insurance or evidence or coverage may be identified. Claim information shall include the total claims made, the total claims paid, the total plan charges and the head count by coverage.

G. 1. If an employer carrier fails to provide the information in the time required by subsection D of this section, the Insurance Commissioner may, after notice and hearing, subject an insurer to a

civil penalty of One Hundred Dollars (\$100.00) for each day that the information is delinquent.

2. If an employer carrier has a risk-bearing contract with a medical group, independent practice association (IPA), or management services organization (MSO) that stipulates the delegation of claims payment, and the carrier satisfies the Insurance Commissioner that the medical group, IPA, or MSO has failed to provide the information to the employer carrier in a sufficient time for the carrier to comply with subsection D of this section, the Commissioner may waive the penalty provided for in paragraph 1 of this subsection.

3. The civil penalty may be enforced in the same manner in which civil judgments may be enforced, as provided in Section 312A of this title. Such penalties shall be placed in the State Insurance Commissioner Revolving Fund. Any person aggrieved by the determination of the Insurance Commissioner may seek judicial review pursuant to Section 320 of this title.

H. The Insurance Commissioner shall promulgate rules for the implementation and administration of this section.

I. As used in this section, "employer carrier" means any entity which provides health insurance in this state. For the purposes of this section, employer 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.

Added by Laws 2002, c. 409, § 1, emerg. eff. June 5, 2002. Amended by Laws 2017, c. 34, § 1, eff. Nov. 1, 2017.

§36-4513. Disclosure of patient insurance coverage and benefit information to medical service providers, health plans or health plan sponsors.

A. All entities providing health insurance or health care coverage to individuals residing within the state shall provide such information on coverage and benefits as may be required by any health care provider, health plan, health plan sponsor or their agent regarding the coverage provided by the entity to any patient or beneficiary of the medical service provider, health plan, or health plan sponsor.

B. Any health care provider, health plan, health plan sponsor or their agent is authorized to transmit the simple human identifiers in ANSI X.12 270 inquiries including the name, gender, date of birth, and member number or policyholder identification number if required by the health plan of a patient to any and all entities licensed or registered to provide health insurance or health care coverage to individuals residing within the state to

establish the coverage in force for a patient presenting or about to present a claim.

C. Any party named in subsection A of this section shall have a cause of action for injunctive relief and costs including, but not limited to, attorney fees for the enforcement of this section against any noncompliant health plan.

Added by Laws 2006, c. 315, § 13, emerg. eff. June 9, 2006.

§36-4521. Short title.

Sections 1 through 9 of this act shall be known and may be cited as the "Employer Health Insurance Purchasing Group Act".

Added by Laws 2002, c. 276, § 1, eff. Nov. 1, 2002.

§36-4522. Definitions.

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 works the number of hours per week designated by the employer as full-time 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" 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.

Added by Laws 2002, c. 276, § 2, eff. Nov. 1, 2002. Amended by Laws 2009, c. 176, § 34, eff. Nov. 1, 2009.

§36-4523. Each group to be nonprofit corporation - Size requirements - Purchase contracts - Enrollment by eligible employees - Filing of reports.

A. Each Health Insurance Purchasing Group (HIPG) shall be a nonprofit corporation operated under the direction of a board of directors, which is composed of five (5) representatives of eligible employers.

B. Each HIPG shall be composed of at least two hundred eligible employees from one or more eligible employers.

1. A HIPG shall have twelve (12) months from the time of formation to reach the level of two hundred eligible employees.

2. At the time of formation, the HIPG shall have at least fifty-one eligible employees.

C. Upon the failure of a HIPG to maintain the required size restrictions described in subsection B of this section, the HIPG shall notify the Commissioner in writing that the HIPG does not comply with the size requirements. The HIPG may then continue to

operate the health benefit plan for its members but shall within sixty (60) calendar days comply with the size requirements of this section, or within a time period as determined by the Commissioner.

D. Upon the failure of the HIPG to maintain size requirements as required under subsection C of this section, after sixty (60) calendar days, or after the time period determined by the Commissioner, the HIPG may then be terminated following notice and hearing before the Commissioner.

E. 1. Subject to the provisions of this act, a HIPG shall permit any eligible employer, which meets the membership requirements of the HIPG, to contract with the HIPG for the purchase of a health benefits plan for its eligible employees and dependents of those eligible employees.

2. The HIPG may not vary conditions of eligibility, including premium rates and membership fees, for any employer meeting the membership requirements of the HIPG, nor may it vary conditions of eligibility for any employee to qualify for a HIPG health benefits plan offered to the eligible employer by the HIPG.

3. A HIPG may not require a contract under this subsection between a HIPG and a purchaser to be effective for a period of longer than twelve (12) months.

4. This shall not be construed to prevent a contract from being extended for additional twelve-month periods or preventing the purchaser from voluntarily electing a contract period of longer than twelve (12) months.

5. A contract shall provide that the purchaser agrees not to obtain or sponsor a health benefits plan, on behalf of any eligible employees and their dependents, other than through the HIPG. This shall not be construed to apply to an eligible individual who resides in an area for which no coverage is offered by a HIPG health carrier.

F. 1. Under rules established to carry out this act, with respect to an eligible employer that has a purchaser contract with a HIPG, individuals who are eligible employees of an eligible employer may enroll for a health benefits plan offered by a HIPG health carrier.

2. The health benefits plan may include coverage for dependents of the enrolling employees, if this coverage is offered.

3. The employees may enroll for health benefits provided through their employer's contract with a HIPG.

G. A HIPG shall not deny enrollment as a member to an individual who is an eligible employee, or dependent of an employee qualified to be enrolled based on health-status-related factors, except as may be permitted by law.

H. In the case of members enrolled in a health benefits plan offered by a HIPG health carrier, the HIPG shall provide for an annual open enrollment period of thirty (30) calendar days during

which the members may change the coverage option in which the members are enrolled.

I. 1. Nothing in this section shall preclude a HIPG from establishing rules of employee eligibility for enrollment and reenrollment of members during the annual open enrollment period under subsection H of this section.

2. The rules shall be applied consistently to all purchasers and members within the HIPG and shall not be based in any manner on health-status-related factors and shall not conflict with sections of this act.

J. 1. Each HIPG shall annually file a report with the Commissioner to be reviewed for approval. The report shall include:

- a. a description of its plan of operation including each of the products it intends to sell,
- b. a description of its marketing methods and materials, and
- c. a description of its membership and disclosure requirements, or other information as required by the Commissioner through rules and regulations.

2. The annual filing required shall be deemed approved upon expiration of a sixty-day waiting period unless, prior to the end of the period, it has been affirmatively approved or disapproved by the Commissioner. The Commissioner may extend the period to approve or disapprove the annual filing by not more than an additional thirty (30) days by giving notice of such extension before expiration of the initial sixty-day period. At the expiration of an extended period, the annual filing shall be deemed approved unless otherwise approved or disapproved by the Commissioner. The Commissioner may at any time, after notice and for cause shown, withdraw approval of an annual report.

K. Each HIPG shall be considered a large group for purposes of application of the Oklahoma Insurance Code to the activities and health benefit plans of the HIPG, unless stated otherwise in this act.

Added by Laws 2002, c. 276, § 3, eff. Nov. 1, 2002.

§36-4524. Rates - Choice of plans - Benefits not required to contain state-mandated benefits - Plan requirements - Premium discounts and modification of copayments or deductibles.

A. Each Health Insurance Purchasing Group (HIPG), in conjunction with a HIPG health carrier, shall make available a health benefits plan in the manner described in this section to all eligible employers and eligible employees at rates, including employers' and employees' shares, on a policy- or product-specific basis which may vary only as permitted under law.

B. Subject to subsection C of this section, a HIPG shall not offer a health benefit plan which unfairly discriminates against eligible employees.

C. Nothing in this act shall be construed as requiring a HIPG health carrier to provide coverage outside the service area of the insurer or organization.

D. Each HIPG shall provide a health benefits plan only through contracts with HIPG health carriers and shall not assume insurance risk with respect to the coverage.

E. Except as provided in this act, the HIPG may develop or offer a health benefits plan for its members, in whole or in part, not subject to state-mandated health benefits.

F. The HIPG shall offer at least two types of plans to its members, including one plan providing a choice of deductibles with state-mandated health benefits.

G. The HIPG may also offer a health benefits plan not subject to state-mandated health benefits which does not contain standard provisions or rights required to be present in a health benefits plan pursuant to law or regulations unrelated to a specific illness, injury or condition of the insured, for the provisions as may be determined by rules and regulations of the Commissioner.

H. Every health benefits plan offered through a HIPG shall:

1. Be underwritten by a HIPG health carrier that:

- a. is licensed or otherwise regulated under state law,
- b. meets all applicable state standards relating to consumer protection, including, but not limited to, state solvency and market conduct, and
- c. offers the coverage under an approved contract with the HIPG;

2. Be approved or otherwise permitted to be offered under law;

3. Provide full portability of creditable coverage for individuals who remain members of the same HIPG notwithstanding that they change the eligible employer through which they are members; and

4. Comply with the provisions of the Oklahoma Insurance Code in their sales and solicitation of insurance including, but not limited to, the Trade Practices Act, and to the degree that an agent is involved in the solicitation, sale or purchase of a health benefits plan offered to a HIPG, that agent must be duly licensed by the State Insurance Department and hold a valid license to transact the business of insurance.

I. A HIPG shall be subject to the requirements of the Small Employer Health Insurance Reform Act.

J. Nothing in this act shall be construed as precluding a HIPG health carrier from offering a health benefits plan through a HIPG by establishing premium discounts for members, or from modifying

otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention, so long as the programs are agreed to in advance by the HIPG and comply with all other provisions of this act and do not discriminate among similarly situated members.

Added by Laws 2002, c. 276, § 4, eff. Nov. 1, 2002.

§36-4525. Filing of forms and plan - Notice required on face page of policy and certificate.

A. Each Health Insurance Purchasing Group (HIPG) shall file forms as may be described by rules and regulations of the Commissioner.

B. Each HIPG health carrier shall file the health benefits plan to be issued to a HIPG pursuant to Article 36 of the Oklahoma Insurance Code.

C. Each HIPG health carrier, which develops or offers a health benefits plan for a HIPG that is a limited benefit plan not subject to state-mandated health benefits, shall specify on the face page of the policy and certificate, printed in ten-point or larger type, a statement that clearly indicates in substance the following:

"IMPORTANT NOTICE: This policy is a limited benefit contract which has been established by a Health Insurance Purchasing Group (HIPG). It may not contain mandated benefits found under Oklahoma Insurance Laws. READ YOUR POLICY CAREFULLY."

Added by Laws 2002, c. 276, § 5, eff. Nov. 1, 2002.

§36-4526. Services for members - Contracts with third-party administrators - Information to be disseminated to members - Administrative charges.

A. Each Health Insurance Purchasing Group (HIPG) may provide administrative services for its members. The services may include, but are not limited to, accounting, billing, enrollment information, and employee coverage status reports.

B. The HIPG may delegate or contract its billing and other administrative duties to a third-party administrator as defined under Article 14B of the Oklahoma Insurance Code.

C. 1. Nothing in this section shall be construed as preventing a HIPG from serving as an administrative service organization to any entity.

2. Each HIPG shall collect and disseminate or arrange for the collection and dissemination of consumer-oriented information on the scope, cost, and enrollee satisfaction of all coverage options offered through the HIPG to its members.

3. The information shall be defined by the HIPG and shall be in a manner appropriate to the type of coverage offered.

4. To the extent practicable, the information shall include information on provider performance, locations, and hours of operation of providers, outcomes, and similar matters.

5. Nothing in this section shall be construed as preventing the dissemination of the information or other information by the HIPG or by the health care insurer through electronic or other means.

D. The contract between a HIPG and a HIPG health carrier shall provide that the HIPG may collect premiums on behalf of the issuer for coverage, less a predetermined administrative charge negotiated by the HIPG and the issuer.

Added by Laws 2002, c. 276, § 6, eff. Nov. 1, 2002.

§36-4527. Members of boards of directors - Conflict of interest - Definition of "affiliated".

A. A member of a board of directors of a Health Insurance Purchasing Group (HIPG) shall not serve as an employee or paid consultant to the HIPG, but may receive reasonable reimbursement for travel expenses for purposes of attending meetings of the board or committees thereof.

B. An individual is not eligible to serve in a paid or unpaid capacity on the board of directors of a HIPG or as an employee of the HIPG, if the individual is employed by, represents in any capacity, owns, or controls any ownership interest in an organization from whom the HIPG receives contributions, rents, or other funds not connected with a contract for coverage through the HIPG.

C. An individual who is serving on a board of directors of a HIPG as a representative described in subsection B of this section shall not be employed by or affiliated with a HIPG health carrier. For purposes of this subsection, the term "affiliated" does not include membership in a health benefits plan or the obtaining of health benefits coverage offered by a HIPG health carrier.

Added by Laws 2002, c. 276, § 7, eff. Nov. 1, 2002.

§36-4528. Areas served - Services and plans permitted to be offered by single administrative organization - Rating characteristics.

A. Nothing in this act shall be construed as preventing one or more Health Insurance Purchasing Groups (HIPG) from serving different areas, whether or not contiguous, by providing for some or all of the following through a single administrative organization or otherwise:

1. Coordinating the offering of the same or similar health benefits coverage in different areas served by the different HIPG; or

2. Providing for crediting of deductibles and other cost-sharing for individuals who are provided a health benefits plan through the HIPG or affiliated HIPG after:

- a. a change of eligible employers through which the coverage is provided, or
- b. a change in place of employment to an area not served by the previous HIPG.

B. No HIPG health carrier shall be required to offer HIPG health benefits plans, or health benefits plans not subject to state-mandated health benefits, to non-HIPG organizations, associations, or employer groups, including but not limited to the small employer health insurance group marketplace in this state.

C. Nothing in this act shall be construed as precluding a HIPG from providing for adjustments in amounts distributed among the HIPG health carriers offering a health benefits plan through the HIPG, based on factors such as the relative health care risk of members enrolled under the coverage offered by the different issuers.

D. Nothing in this act shall be construed as precluding a HIPG from establishing minimum participation and contribution rules for eligible employers that apply to become purchasers in the HIPG, so long as the rules are applied uniformly for all HIPG health carriers.

E. The HIPG may determine what rating characteristics it will allow in the health benefit plan including, but not limited to, age, sex, industry, geography, or health.

F. If health is used as a rating characteristic, then the rates for the groups having two through fifty members will be subject to the small employer group rating law as required in the Small Employer Health Insurance Reform Act but may be considered separate from any small groups sold outside the HIPG.

Added by Laws 2002, c. 276, § 8, eff. Nov. 1, 2002.

§36-4529. Rules.

The Commissioner may promulgate rules necessary to implement the provisions of this act.

Added by Laws 2002, c. 276, § 9, eff. Nov. 1, 2002.

§36-4601. Short title.

This act shall be known and may be cited as the "Health Care for Oklahomans Act".

Added by Laws 2009, c. 128, § 1, eff. Nov. 1, 2009.

§36-4602. Duties of Insurance Commissioner, State Board of Health, and Health Care for Uninsured Board.

A. The Insurance Commissioner in collaboration with the Oklahoma Health Care Authority shall advise and aid the Health Care for the Uninsured Board (HUB) in its duties. The Insurance Commissioner is hereby authorized to promulgate such reasonable rules as are necessary to implement the purposes of this act.

B. The State Board of Health shall direct the implementation and duties of the HUB to assist the Insurance Commissioner. The duties of the HUB shall be to:

1. Advise, consult with, and make recommendations to the Commissioner as to the matters addressed in subsection C of this section; and

2. Assist and advise the Commissioner on such other matters as the Commissioner may submit for recommendations to the State Board of Health.

C. The Commissioner shall:

1. Establish a system of certification for insurance programs offered in this state to be recommended by the HUB;

2. Establish a system for the credentialing of insurance producers who intend to market insurance programs certified by the state in accordance with this section.

3. Establish a system of counseling, including a website, for those individuals who are without health insurance and are not covered by Medicaid, that includes but is not limited to:

- a. educating consumers about insurance programs certified by the state in accordance with this section,
- b. aiding consumers in choosing policies that cover medically necessary services for that consumer, and
- c. educating consumers on how to utilize primary and preventative care in order to reduce the unnecessary utilization of services by the consumer; and

4. Establish a system whereby if an individual qualifies for a subsidy under the premium assistance program, established in Section 1010.1 of Title 56 of the Oklahoma Statutes, that person is able to become enrolled through the HUB in conjunction with local, qualified insurance producers.

Added by Laws 2009, c. 128, § 2, eff. Nov. 1, 2009.

§36-4603. Enrollment in health insurance programs of uninsured individuals and individuals not covered by Medicaid.

A. The Insurance Commissioner in collaboration with the Oklahoma Health Care Authority shall initiate a program to encourage enrollment of individuals, not covered by insurance or Medicaid in health insurance programs.

B. Upon treatment of an uninsured individual or an individual not covered by Medicaid, a health care provider shall refer the individual to the HUB established in Section 2 of this act to begin the enrollment process in a certified insurance plan or the premium assistance program established in Section 1010.1 of Title 56 of the Oklahoma Statutes, if eligible.

Added by Laws 2009, c. 128, § 3, eff. Nov. 1, 2009.

§36-4604. Direct primary care membership agreement.

A. This act shall be known and may be cited as the "Health Care Empowerment Act".

B. Nothing in state law shall be construed as prohibiting a patient or legal representative from seeking care outside of an insurance plan, or outside of the Medicaid or Medicare program, and paying for such care.

C. Nothing in state law shall be construed as prohibiting a physician, other medical professional or a medical facility from accepting payment for services or medical products outside of an insurance plan. Nothing in state law shall be construed as prohibiting a physician, other medical professional or a medical facility from accepting payment for services or medical products to a Medicaid or Medicare beneficiary, provided that such physician, medical professional or medical facility has opted out of Medicare. As used in this section, "medical products" include, but are not limited to, medical drugs and pharmaceuticals.

D. A patient or legal representative shall not forfeit insurance benefits, Medicaid benefits or Medicare benefits by purchasing medical services or medical products outside the system.

E. The offer and provision of medical services or medical products purchased and provided under this act shall not be deemed an offer of insurance nor regulated by the insurance laws of the state.

F. Providers must disclose the text of the Enrollee Hold Harmless Clause, or its equivalent, in insurance or managed care provider contracts to patients or legal representatives if authorization for services or claims is denied, together with a plain-English explanation of its meaning.

Added by Laws 2015, c. 159, § 1, emerg. eff. April 21, 2015.

§36-4605. Direct primary care membership agreement.

A. As used in this section, "direct primary care membership agreement" means a contractual agreement between a primary care provider and an individual patient, or his or her legal representative, in which:

1. The provider agrees to provide primary care services to the individual patient for an agreed-to fee over an agreed-to period of time;

2. The direct primary care provider will not bill third parties on a fee-for-service basis; and

3. Any per-visit charges under the agreement will be less than the monthly equivalent of the periodic fee.

A "direct primary care provider" means an individual or legal entity that is licensed, registered or otherwise authorized to provide primary care services in this state and who chooses to enter into a direct primary care membership agreement. This includes, but is not limited to, an individual primary care provider or other

legal entity alone or with others professionally associated with the individual or other legal entity.

B. A direct primary care membership agreement is not insurance and is not subject to regulation by the Insurance Department.

C. Entering into a direct primary care membership agreement is not the business of insurance and is not subject to regulations under the Oklahoma Insurance Code.

D. A direct primary care provider or the agent of a direct primary care provider is not required to obtain a certification of authority or license under Title 36 of the Oklahoma Statutes to market, sell or offer to sell a direct primary care agreement.

E. A direct primary care membership agreement is not a medical discount plan, as defined by state law or regulation under the Insurance Department and a direct primary care provider is not required to register as a medical discount plan.

F. A direct primary care membership agreement shall:

1. Allow either party to terminate the agreement upon written notice to the other party;

2. Provide that fees are not earned by the direct primary care provider until the month paid by the periodic fee has been completed; and

3. Provide that, upon termination of this agreement by the individual patient, all unearned fees are to be returned to the patient.

Added by Laws 2015, c. 159, § 2, emerg. eff. Apr. 21, 2015.

§36-4801. Scope of article.

A. This article shall not apply to vehicle insurance, casualty insurance or inland marine insurance, nor to reinsurance.

B. The standard fire insurance policy provided for herein shall not be required for (1) vehicle insurance, (2) casualty insurance, (3) inland marine insurance, as defined in Section 705, Article 7, (4) ocean marine insurance, (5) insurance on growing crops, or (6) in effecting reinsurance between insurers.

Laws 1957, p. 401, § 4801.

§36-4802. "Fire insurance" defined.

"Fire insurance" is insurance against the perils of fire or lightning as written under the Oklahoma standard fire insurance policy.

Laws 1957, p. 401, § 4802.

§36-4803. Standard policy provisions - Permissible variations.

A. The printed form of a policy of fire insurance as set forth in subsection G of this section shall be known and designated as the standard fire insurance policy to be used in the State of Oklahoma.

B. Except as provided in subsection F of this section, no policy or contract of fire insurance shall be made, issued or delivered by any insurer or by any agent or representative thereof, on any property in the state, unless it shall conform as to all provisions, stipulations, agreements and conditions, with such form of policy.

There shall be printed at the head of said policy the name of the insurer or insurers issuing the policy; the location of the home office or United States Office thereof; a statement as to whether said insurer or insurers are stock or mutual corporations or are reciprocal insurers or Lloyd's underwriters; and there may be added to the policy such device or devices as the insurer or insurers issuing said policy shall desire. Any company organized under special charter provisions may so indicate upon its policy, and may add to the policy a statement of the plan under which it operates in this state.

If the policy is issued by a mutual, cooperative or reciprocal insurer having special regulations with respect to the payment by the policyholder of assessments, such regulations shall be made a part of the policy, and any such insurer may print upon the policy such regulations as may be appropriate to or required by its home state or its form of organization.

There may also be added a statement of the group insurers with which the insurer is financially affiliated.

In lieu of the facsimile signatures of the president and secretary of the insurer there may be used the name or names of such officers or managers as are authorized to execute the contract.

C. Appropriate forms of additional contracts, riders or endorsements, insuring against indirect or consequential loss or damage or against any one or more perils other than those of fire and lightning, or providing coverage which the insurer issuing the policy is authorized by charter and by the laws of this state to assume or issue, may be issued in connection with the standard fire policy.

Such other perils or coverages may include those excluded in the standard fire insurance policy, and may include any of the perils or coverages permitted to be insured against or issued by property and casualty insurers. Such forms of contracts, riders and endorsements may contain provisions and stipulations inconsistent with such standard fire insurance policy, if said provisions and stipulations are applicable only to such additional coverage or to the additional peril or perils insured against.

D. Provisions to be contained on the first page of the policy may be rewritten, supplemented, or rearranged to facilitate policy issuance and to include matter which may otherwise properly be added by endorsement.

The pages of the standard fire insurance policy may be renumbered and the format rearranged for convenience in the preparation of individual contracts, and to provide space for the listing of rates and premiums for coverages insured hereunder or under endorsements attached or printed thereon, and such other data as may be conveniently included for duplication on daily reports for office records.

E. There may be printed upon the standard fire policy the words "Standard Fire Insurance Policy for Oklahoma", and there may be inserted before and after the word "Oklahoma" a designation of any state or states in which such form of policy is standard.

There may be endorsed on any such policy the name, with the word "agent" or "agents" and place of business, or any insurance agent or agents either by writing, printing, stamping or otherwise.

F. Notwithstanding any other provision of this section, the Insurance Commissioner may approve for use within the state any form of policy with variations in terms and conditions from the standard fire insurance policy provided for in this section.

G. The form of the standard fire insurance policy, with permission to substitute for the word "company" a more accurate descriptive term for the type of insurer, shall be as follows:

(FIRST PAGE OF) STANDARD FIRE INSURANCE POLICY

NO.

(Space for insertion of name of company or companies issuing the policy and other matter permitted to be stated at the head of the policy.)

(Space for listing amounts of insurance, rates and premiums for the basic coverages insured under the standard form of policy and for additional coverages or perils insured under endorsements attached.)

IN CONSIDERATION OF THE PROVISIONS AND STIPULATIONS HEREIN OR ADDED HERETO AND OF the premium above specified, this Company, for the term of _____ from _____ at Noon (Standard Time) to _____ at Noon (Standard Time)

at location of property involved, to an amount not exceeding the amount(s) above specified, does insure

and legal representatives, to the extent of the actual cash value of the property at the time of loss, but not exceeding the amount which it would cost to repair or replace the property with material of like kind and quality within a reasonable time after such loss, without allowance for any increased cost of repair or reconstruction by reason of any ordinance or law regulating construction or repair, and without compensation for loss resulting from interruption of business or manufacture, nor in any event for more than the interest of the insured, against all DIRECT LOSS BY FIRE, LIGHTNING AND BY REMOVAL FROM PREMISES ENDANGERED BY THE PERILS INSURED AGAINST IN THIS POLICY, EXCEPT AS HEREINAFTER PROVIDED, to the property described hereinafter while located or contained as described in

this policy, or pro rata for five days at each proper place to which any of the property shall necessarily be removed for preservation from the perils insured against in this policy, but not elsewhere.

Assignment of this policy shall not be valid except with the written consent of this Company.

This policy is made and accepted subject to the foregoing provisions and stipulations and those hereinafter stated, which are hereby made a part of this policy, together with such other provisions, stipulations and agreements as may be added hereto, as provided in this policy.

IN WITNESS WHEREOF, this Company has executed and attested these presents; but this policy shall not be valid unless countersigned by the duly authorized Agent of this Company at

Signature of proper officer or officers.

Countersigned this _____ day of _____, 19_____
Agent.

(SECOND PAGE OF) STANDARD FIRE INSURANCE POLICY

Concealment, fraud. This entire policy shall be void if, whether before or after a loss, the insured has willfully concealed or misrepresented any material fact or circumstance concerning this insurance or the subject thereof, or the interest of the insured therein, or in case of any fraud or false swearing by the insured relating thereto.

Uninsurable and excepted property. This policy shall not cover accounts, bills, currency, deeds, evidences of debt, money or securities; nor, unless specifically named hereon in writing, bullion or manuscripts.

Perils not included. This Company shall not be liable for loss by fire or other perils insured against in this policy caused, directly or indirectly, by: (a) enemy attack by armed forces, including action taken by military, naval or air forces in resisting an actual or an immediately impending enemy attack; (b) invasion; (c) insurrection; (d) rebellion; (e) revolution; (f) civil war; (g) usurped power; (h) order of any civil authority except acts of destruction at the time of and for the purpose of preventing the spread of fire, provided that such fire did not originate from any of the perils excluded by this policy; (i) neglect of the insured to use all reasonable means to save and preserve the property at and after a loss, or when the property is endangered by fire in neighboring premises; (j) nor shall this Company be liable for loss by theft.

Other Insurance. Other Insurance may be prohibited or the amount of insurance may be limited by endorsement attached hereto.

Conditions suspending or restricting insurance. Unless otherwise provided in writing added hereto this Company shall not be liable for loss occurring

(a) while the hazard is increased by any means within the control or knowledge of the insured; or

(b) while a described building, whether intended for occupancy by owner or tenant, is vacant or unoccupied beyond a period of sixty consecutive days; or

(c) as a result of explosion or riot, unless fire ensues, and in that event for loss by fire only.

Other perils or subjects. Any other peril to be insured against or subject of insurance to be covered in this policy shall be by endorsement in writing hereon or added hereto.

Added provisions. The extent of the application of insurance under this policy and of the contribution to be made by this Company in case of loss, and any other provision or agreement not inconsistent with the provisions of this policy, may be provided for in writing added hereto, but no provision may be waived except such as by the terms of this policy is subject to change.

Waiver provisions. No permission affecting this insurance shall exist, or waiver of any provision be valid, unless granted herein or expressed in writing added hereto. No provision, stipulation or forfeiture shall be held to be waived by any requirement or proceeding on the part of this Company relating to appraisal or to any examination provided for herein.

Cancellation of policy. This policy shall be canceled at any time at the request of the insured, in which case this Company shall, upon demand and surrender of this policy refund the excess of paid premium above the customary short rates for the expired time. This policy may be canceled at any time by this Company by giving to the insured a five days' written notice of cancellation with or without tender of the excess of paid premium above the pro rata premium for the expired time, which excess, if not tendered shall be refunded on demand. Notice of cancellation shall state that said excess premium (if not tendered) will be refunded on demand.

Mortgagee interests and obligations. If loss hereunder is made payable, in whole or in part, to a designated mortgagee not named herein as the insured, such interest in this policy may be canceled by giving such mortgagee a ten days' written notice of cancellation.

If the insured fails to render proof of loss such mortgagee, upon notice, shall render proof of loss in the form herein specified within sixty (60) days after, and shall be subject to the provisions hereof relating to appraisal and time of payment and of bringing suit. If this Company shall claim that no liability existed as to the mortgagor or owner, it shall, to the extent of payment of loss to the mortgagee, be subrogated to all the mortgagee's rights of recovery, but without impairing mortgagee's right to sue, or it may

pay off the mortgage debt and require an assignment thereof and of the mortgage. Other provisions relating to the interests and obligations of such mortgagee may be added hereto by agreement in writing.

Pro rata liability. This Company shall not be liable for a greater proportion of any loss than the amount hereby insured shall bear to the whole insurance covering the property against the peril involved, whether collectible or not.

Requirements in case loss occurs. The insured shall give immediate written notice to this Company of any loss, protect the property from further damage, forthwith separate the damaged and undamaged personal property, put it in the best possible order, furnish a complete inventory of the destroyed, damaged and undamaged property, showing in detail quantities, costs, actual cash value and amount of loss claimed; and within sixty days after the loss, unless such time is extended in writing by the Company, the insured shall render to this Company a proof of loss, signed and sworn to by the insured, stating the knowledge and belief of the insured as to the following: the time and origin of the loss, the interest of the insured and of all others in the property, the actual cash value of each item thereof and the amount of loss thereto, all encumbrances thereon, all other contracts of insurance, whether valid or not, covering any of said property, any changes in the title, use, occupation, location, possession or exposures of said property since the issuing of this policy, by whom and for what purpose any building herein described and the several parts thereof were occupied at the time of loss and whether or not it then stood on leased ground, and shall furnish a copy of all the descriptions and schedules in all policies and, if required, verified plans and specifications of any building, fixtures or machinery destroyed or damaged. The insured, as often as may be reasonably required, shall exhibit to any person designated by this Company all that remains of any property herein described, and submit to examinations under oath by any person named by this Company, and subscribe the same, and as often as may be reasonably required, shall produce for examination all books of account, bills, invoices and other vouchers or certified copies thereof if originals be lost, at such reasonable time and place as may be designated by this Company or its representative, and shall permit extracts and copies thereof to be made.

Appraisal. In case the insured and this Company shall fail to agree as to the actual cash value or the amount of loss, then, on the written demand of either, each shall select a competent and disinterested appraiser and notify the other of the appraiser selected within twenty (20) days of such demand. The appraisers shall first select a competent and disinterested umpire; and failing for fifteen (15) days to agree upon such umpire, then, on request of

the insured or this Company, after notice of hearing to the nonrequesting party by certified mail, such umpire shall be selected by a judge of a district court in the county where the loss occurred. The appraisers shall then appraise the loss, stating separately actual cash value and loss to each item, and, failing to agree, shall submit their differences, only, to the umpire. An award in writing, so itemized, of any two when filed with this Company shall determine the amount of actual cash value and loss. Each appraiser shall be paid by the party selecting him and the expenses of appraisal and umpire shall be paid by the parties equally.

Company's option. It shall be optional with this Company to take all, or any part, of the property at the agreed or appraised value, and also to repair, rebuild or replace the property destroyed or damaged with other of like kind and quality within a reasonable time, on giving notice of its intention so to do within thirty days after the receipt of the proof of loss herein required.

Abandonment. There can be no abandonment to this Company of any property.

When loss payable. The amount of loss for which this Company may be liable shall be payable sixty days after proof of loss, as herein provided, is received by this Company and ascertainment of the loss is made either by agreement between the insured and this Company expressed in writing or by the filing with this Company of an award as herein provided.

Suit. No suit or action on this policy for the recovery of any claim shall be sustainable in any court of law or equity unless all the requirements of this policy shall have been complied with, and unless commenced within twelve months next after inception of the loss.

Subrogation. This Company may require from the insured an assignment of all right of recovery against any party for loss to the extent that payment therefor is made by this Company.

(THIRD PAGE OF) STANDARD FIRE INSURANCE POLICY
ATTACH FORMS BELOW THIS LINE

(BACK OF STANDARD FIRE INSURANCE POLICY)

Expires _____
Property _____
Total
Amount \$ _____ Premiums \$ _____
Insured _____

SEE INSIDE OF POLICY FOR
PERILS COVERED

No. _____
(COMPANY)

It is important that the written portions of all policies covering the same property read exactly alike. If they do not, they should be made uniform at once.

Added by Laws 1957, p. 401, § 4803, operative July 1, 1957. Amended by Laws 1985, c. 100, § 1, eff. Nov. 1, 1985; Laws 1989, c. 181, § 9, eff. Nov. 1, 1989; Laws 1993, c. 222, § 1, eff. Sept. 1, 1993; Laws 2003, c. 358, § 2, eff. Nov. 1, 2003.

§36-4803.1. Fire insurance policies - Time of expiration.

All fire insurance policies, as defined by Section 4802 of Title 36 of the Oklahoma Statutes, shall expire at 12:01 a.m. Standard Time on the expiration date stated in the policy. This section shall apply to all fire insurance policies on the first policy renewal date after December 31, 1982.

Added by Laws 1982, c. 57, § 2, eff. Jan. 1, 1983.

§36-4804. Policy limited - Liability - Excess premiums reimbursed.

No insurance company shall, knowingly, issue any fire insurance policy upon property within this state for an amount which, with any existing insurance thereon, exceeds the fair value of the property. If buildings insured against loss by fire, and situated within this state, are totally destroyed by fire, the company shall not be liable beyond the actual value of the insured property at the time of the loss or damage, and if it shall appear that the insured has paid premiums on an amount in excess of said actual value, the assured shall be reimbursed the proportionate excess of premiums paid on the difference between the amount named in the policy and said actual value, with interest at six percent (6%) per annum from the date of issue.

Added by Laws 1957, p. 406, § 4804. Amended by Laws 2001, c. 363, § 24, eff. July 1, 2001.

§36-4805. Proofs of loss - Conditions of enforcement of limitation of time.

When any insurance policy subject to the provisions of this article contains a provision that the insured must render a written sworn proof of loss within sixty (60) days from the date of fire or loss to the insurer, or the same is required by law to be so rendered, the insurer cannot assert the failure of insured to so render such proof of loss in any litigation or court proceeding, unless the insurer plead and prove that it has furnished the insured with two blank forms for the execution of proof of loss, that has printed thereon, in bold-faced type in a conspicuous place, the warning that a proof of loss must be rendered to the insurer within sixty (60) days from the date of receipt of the blank forms for proof of loss by the insured, or by putting such warning in a like form in a letter of instruction for executing a proof of loss that

will accompany the proof of loss blanks furnished the insured, and the insurer has further executed and furnished the insured its written extension of time, giving the insured sixty (60) days from the date such blanks were received by the insured. These requirements cannot be waived by any agreement between the parties or otherwise.

Laws 1957, p. 406, § 4805. der

§36-4806. Exclusion of loss caused by nuclear reaction, nuclear radiation or radioactive contamination.

Insurers issuing the standard form of fire insurance policy provided in Section 4803, Article 48, Title 36, Oklahoma Session Laws 1957, page 401 (36 O.S. Supp.1959, Section 4803), are authorized to affix thereto or include therein a written statement that such policy does not cover loss or damage caused by nuclear reaction or nuclear radiation or radioactive contamination, all whether directly or indirectly resulting from an insured peril under said policy; provided, however, that nothing herein contained shall be construed to prohibit the attachment to any such policy of an endorsement or endorsements specifically assuming coverage for loss or damage caused by nuclear reaction, nuclear radiation, or radioactive contamination.

Laws 1961, p. 279, § 1.

§36-4808. Homeowner's policies - Automatic increase in coverage.

No homeowner's policy shall automatically increase coverage for replacement of a home of an insured unless the insured or his designated representative has been notified of the amount of increased replacement coverage not less than thirty (30) days prior to the renewal date. The provisions of this section shall not apply if the insured provides to the insurer written consent to automatic increases in coverage. Any written consent provided under this section shall remain continuously in force until the insured provides written revocation to the insurer.

Provided, nothing in this section shall be construed to relieve the insurer from paying the full value of any claim against the policy up to the maximum amount for which the home is insured. Added by Laws 1987, c. 140, § 1, eff. Nov. 1, 1987. Amended by Laws 1992, c. 75, § 1, eff. Sept. 1, 1992.

§36-4809. Reduced rates to persons failing or refusing to pay assessments - Violation - Penalties.

A. Except as otherwise provided in this subsection, no property or casualty insurance company shall give any special or reduced rate for fire insurance on any risk because it is located in a rural fire protection district or in an area protected by a rural fire department in which the district or department is wholly or

partially funded by dues or subscription payments paid by owners of property who are members of an association supporting the rural fire department to any person who fails or refuses to pay the appropriate dues or subscription payments for support of the district or department pursuant to the procedure outlined in subsection C of this section. Property and casualty insurance companies providing a fire run service benefit payment within the fire insurance policy shall not be subject to this subsection.

B. Property owners owning property in more than one fire district or fire department area relying on dues or subscriptions for partial or complete funding shall pay dues to a fire district or fire department in whose district or area they own property if they wish to receive special or reduced rates for property and casualty insurance.

C. Except as otherwise provided in this subsection, it is unlawful for any insurance agent or company to knowingly write an initial policy of fire insurance coverage on any risk located in a rural fire protection district or in any area protected by a rural fire department at any special or reduced rate or with any rate credit based on location of the risk in the district or area without having first obtained from the insured or from the rural fire protection district or rural fire department evidence that current dues or subscription payments, if any, for the property to be insured have been paid. Following the writing of the initial policy, the insurance agent or company shall obtain evidence of successful payment of current dues or subscription payments annually. The evidence required by the insurer may be a receipt, canceled check, or other valid proof of payment. Any insurance agent or company writing a policy of fire insurance coverage providing a fire run service benefit payment within the fire insurance policy shall not be subject to this subsection.

D. If any agent is found by the Insurance Commissioner to have violated the provisions of this subsection, the agent shall be liable for an administrative penalty of Twenty-five Dollars (\$25.00) for the first violation and Fifty Dollars (\$50.00) for any subsequent violation.

Added by Laws 2002, c. 68, § 1, eff. Nov. 1, 2002. Amended by Laws 2003, c. 235, § 1, eff. Nov. 1, 2003; Laws 2017, c. 317, § 1, eff. Nov. 1, 2017.

§36-4901. Sole surety on official bonds.

Whenever any bond, recognizance, or undertaking is required or permitted to be made for the security or protection of any person or municipality, the state, or any department thereof, or organization, conditioned for the doing or not doing of anything therein specified, any such board, court, organization or officer required or permitted to accept or approve of the sufficiency of such bond,

recognizance, or undertaking, may accept and approve the same when executed, or when the conditions thereof are guaranteed, solely by an insurer authorized to transact a surety business in this state in accordance with the requirements of this code. Whenever any such bond, recognizance, or undertaking is required to be made with one surety or with two or more sureties, the execution of the same, or the guarantee of the performance of the conditions thereof, shall be sufficient when so executed or guaranteed solely by one such insurer, and shall be a full compliance with every requirement of every law, ordinance, or regulation relating to the same, and no justification by such insurer shall be necessary.

Laws 1957, p. 407, § 4901.

§36-4902. Venue of actions against surety insurers.

Any surety insurer may be sued in respect of any surety bond by it issued in the county where such bond, recognizance, stipulation or undertaking was made or guaranteed, or in the county where the principal office of such insurer in this state is located, and for the purposes hereof, the same shall be treated as made or guaranteed in the county in which such office is located or in which it is filed, or in the county in which the principal resided when it was made or guaranteed.

Laws 1957, p. 407, § 4902.

§36-4903. Bail bond surety companies - Reserve funds.

All surety companies which execute undertakings of bail shall keep any moneys collected from agents licensed pursuant to Section 1303 of Title 59 of the Oklahoma Statutes as buildup or reserve funds in segregated interest-bearing trust accounts within this state in an entity which is insured either by the Federal Deposit Insurance Corporation or the Federal Savings and Loan Insurance Corporation.

The interest-bearing trust accounts shall not be pledged or offered as collateral.

The moneys in the interest-bearing trust accounts shall be used to satisfy the unfulfilled obligations of the undertakings of bail written by the agents from whom the moneys have been collected and to otherwise satisfy the unfulfilled obligations which may be owing to the surety by such agents.

Added by Laws 1987, c. 211, § 1 eff. Nov. 1, 1987.

§36-4904. Bail bond insurers - Financial statement - Reports.

A. Each insurer writing bail bonds in this state shall file in the Office of the Insurance Commissioner quarterly statements which shall exhibit the financial condition of the insurer. The statements shall be in such general form and content as approved by the National Association of Insurance Commissioners for the kinds of

insurance to be reported, and as supplemented for additional information as required by the Commissioner. Such statements shall be subscribed and sworn by the president and secretary and other proper officers of the insurer. The statements shall be filed on or before the following dates:

1. First quarter statement, which shall include data from January 1 to March 31, on the last business day in April;
2. Second quarter statement, which shall include data from April 1 to June 30, on the last business day of July;
3. Third quarter statement, which shall include data from July 1 to September 30, on the last business day of October; and
4. Annual financial statement as described in Section 311 of this title, which shall serve as fourth quarter statement and which shall be filed annually on the date specified in Section 311 of this title, in the office of the Commissioner by each insurer writing bail bonds.

B. The statements required to be filed pursuant to subsection A of this section shall contain the loss reserve for bail bonds written in this state. Loss reserves shall be computed as twenty-five percent (25%) of the direct written premium of outstanding liability less monies held by the insurer in trust to pay losses from bail.

C. Each insurer writing bail bonds in this state shall file monthly reports based upon the previous month's activity with the Commissioner and on forms prescribed by the Commissioner within thirty (30) days after the end of each preceding month, which shall include the following information and such other information as the Commissioner deems necessary:

1. Amount of deposit held by the Commissioner with a list of the securities available and their current valuation;
2. Bail bond premium volume for this state;
3. Administrative action, if any, taken by other states against the insurer;
4. List of collateral held by the insurer stating the location of collateral, the corresponding county involved, the case number and the bondsman soliciting the bond;
5. Loss ratio;
6. Outstanding liability; and
7. A list of agents or bondsmen whose contracts have been canceled.

Added by Laws 1987, c. 211, § 2, eff. Nov. 1, 1987. Amended by Laws 1992, c. 98, § 1, eff. Sept. 1, 1992.

§36-5001. Certificates of authority – Persons not deemed title insurers – Issuance of policies.

A. Any foreign or domestic stock insurer authorized by its corporate charter to engage in business as a title insurer shall be

entitled to the issuance of a certificate of authority as a title insurer in this state upon meeting the applicable requirements of Article 6, Authorization of Insurers and General Requirements, of the Oklahoma Insurance Code, except that existing title insurers may have their certificate of authority renewed by maintaining surplus in regard to policyholders of not less than Five Hundred Thousand Dollars (\$500,000.00).

B. A person engaged in the business of preparing or issuing abstracts of, but not guaranteeing or insuring, title to property, or a person acting only as a title insurance producer appointed by a title insurer, shall not be deemed to be a title insurer.

C. Every commitment and policy of title insurance issued by any insurance company authorized to do business in this state shall be countersigned by some person, partnership, corporation or agency actively engaged in the real estate title business and maintaining an office in the state, who is a duly appointed a title insurance producer for a title insurance company holding a valid license and authorized to do business in the state; provided, that no commitment or policy of title insurance shall be issued in the State of Oklahoma except:

1. After examination by an attorney licensed to practice in this state of a duly certified abstract extension or supplemental abstract prepared by an abstractor licensed in the county where the property is located, from a certified abstract plant in the county where the property is located or per a temporary certificate of authority as provided in Section 33 of Title 1 of the Oklahoma Statutes, from the effective date of a prior owner's policy of title insurance issued by a title insurer licensed in this state provided by the insured, the prior title insurance producer or the prior title insurer, at the time a valid order is placed pursuant to the provisions of the Oklahoma Abstractors Law brought forward to the effective date of the abstract plant. Subject to the conditions and stipulations, the exclusions from coverage, exceptions from coverage and endorsements to the policy, any policy issued based on a prior owner's policy and a supplemental abstract shall insure the insured against loss or damage sustained or incurred by reason of unmarketability of title from sovereignty to the effective date of the policy, not to exceed the amount of insurance stated in the policy; or

2. If a prior owner's policy of title insurance is not provided, then a title insurance commitment and policy may be issued after examination by an attorney licensed to practice in this state of a duly certified abstract of title prepared by a bonded and licensed abstractor as defined in the Oklahoma Abstractors Law.

D. If the current owner or insured, or the owner's or insured's authorized agent requests, in writing, a copy of any previously issued owner's policy, the title insurance producer or the title

insurer that issued the policy shall provide the requesting party with a copy of the schedules in the previously issued policy, at no charge, within three (3) business days, unless there exists an unavoidable delay.

E. As used in this section, the term "representative" shall mean a person authorized to act on behalf of or in place of another in the current transaction.

F. Every title insurance producer, title insurer or person who conducts a real estate closing that presents, for filing in the office of the county clerk, an instrument of conveyance or vesting title in connection with a transaction in which an owner's policy of title insurance is to be issued by a title insurance producer or title insurer that is based upon such instrument shall place a legend within the instrument that sets forth the following information:

Deed presented for filing by: [Name of title insurance producer, title insurer or person conducting closing]

File Number: [File Number of title insurance producer, title insurer or person conducting closing]

[Name of Title Insurer designated in the Commitment for Title Insurance]

G. The Insurance Department shall maintain, for each title insurance producer or title insurer holding a valid license and authorized to do business in the state, contact information for the office or person responsible for making available copies of owner's policies pursuant to this statute and shall make such contact information generally available to the public on its website and by telephone request.

H. The Insurance Commissioner may promulgate rules and regulations to carry out the provisions of this section.

Added by Laws 1957, p. 407, § 5001, operative July 1, 1957. Amended by Laws 1959, p. 138, § 1, emerg. eff. June 30, 1959; Laws 1980, c. 185, § 7, eff. Oct. 1, 1980; Laws 2006, c. 269, § 1, eff. July 1, 2007; Laws 2013, c. 64, § 1, eff. Nov. 1, 2013; Laws 2017, c. 148, § 2, eff. Nov. 1, 2017; Laws 2018, c. 285, § 1, eff. Nov. 1, 2018; Laws 2024, c. 10, § 1, eff. Nov. 1, 2024.

§36-5002. Investments of title insurers.

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. Domestic title insurers shall 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.

Added by Laws 1957, p. 407, § 5002, operative July 1, 1957. Amended by Laws 2008, c. 184, § 21, eff. July 1, 2008; Laws 2009, c. 176, § 35, eff. Nov. 1, 2009.

§36-5003. Additional powers of title insurers.

A title insurer may engage in such other business not inconsistent with the business of issuing title insurance policies as may be authorized by its corporate charter.

Laws 1957, p. 408, § 5003.

§36-5004. "Title insurance policy" and "aircraft title insurance policy" - Definitions.

A. A "title insurance policy" is any written instrument purporting to show the title to real or personal property or any interest therein or encumbrance thereon, or to furnish such information relative to real property, which written instrument in express terms purports to insure or guarantee such title or the correctness of such information.

B. An "aircraft title insurance policy" is any written instrument purporting to show title to aircraft or any interest therein or encumbrance thereon, which written instrument in express terms 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.

Added by Laws 1957, p. 408, § 5004, operative July 1, 1957. Amended by Laws 2006, c. 264, § 61, eff. July 1, 2006.

§36-5005. Exemptions and application of other laws.

A. Title insurers shall be governed by this article and, to the extent not modified by or inconsistent with the provisions of this article or the provisions of this code made applicable to such insurers, by the general laws of this state governing corporations organized for profit.

B. To the extent not modified by the provisions of this article, title insurers shall be subject to and governed by the other applicable provisions of this code.

C. No new insurance law hereafter enacted shall be deemed to apply to title insurers unless they be expressly referred to therein.

D. Notwithstanding anything to the contrary, the following sections, acts and articles of the Insurance Code and related rules of the Insurance Department shall apply to title insurers in addition to those applicable to title insurers on November 1, 2008:

1. Section 311 of this title, Annual Financial Statements;

2. Section 615.2 of this title, Duty of Domestic Insurers and Health Maintenance Organizations to Keep Biographical Information Current;

3. Article 12, Unfair Practices and Frauds;

4. Article 12A-1, Unfair Claims Settlement Practices Act;

5. Article 16A, Subsidiaries of Insurers;

6. Article 18, Supervision and Conservatorship of Insurers Act;
and

7. Article 19, Rehabilitation and Liquidation.

Added by Laws 1957, p. 408, § 5005, operative July 1, 1957. Amended by Laws 2008, c. 184, § 22, eff. July 1, 2008.

§36-5006. Examination of title insurance company.

The Insurance Commissioner is authorized to conduct an examination of any title insurance company pursuant to the provisions of Section 309.1 et seq. of Title 36 of the Oklahoma Statutes and may employ an examiner for such purposes.

Added by Laws 1995, c. 339, § 18, eff. Nov. 1, 1995 and by Laws 1995, c. 356, § 3, eff. Nov. 1, 1995.

§36-5007. Statutory premium reserve.

A. Statutory Premium Reserve Required.

1. Each domestic title insurer doing title insurance business under this chapter shall establish and maintain a statutory premium reserve during the period and for the uses and purposes provided by this article, which shall at all times and for all purposes be deemed and shall constitute unearned portions of the original premium, and shall be charged as a reserve liability of that insurer in determining its financial condition.

2. The reserve required under this section shall be cumulative. The reserve shall be established and shall consist of the amounts required under this article.

B. Annual Additions to Reserves for Calendar Year 2014 and Thereafter.

1. For companies with annual gross premiums of Twenty Million Dollars (\$20,000,000.00) or more, beginning with premiums received on January 1, 2015, the statutory premium reserve shall consist of an amount not less than five percent (5%) of the sum of the following, as set forth in the title insurer's annual statement:

- a. the direct premium written by the title insurer, and
- b. premium for reinsurance assumed less premium for reinsurance ceded during the year.

2. Companies with annual gross premiums of less than Twenty Million Dollars (\$20,000,000.00) may, at their election, establish premium reserves as set forth in paragraph 1 of subsection B of this section, or alternatively, in an amount not less than the title insurer's reserve for incurred but not reported claims (IBNR) plus the reserve for unallocated loss adjustment expense (ULAE). For companies electing the latter option, the remainder of subsections B and C of this section do not apply.

3. The statutory premium reserve calculations in subsection B of this section are minimum amounts. A title insurance underwriter may set aside amounts in excess of the minimum reserve requirement.

4. Additions to the statutory premium reserve set aside for title insurance policies written or assumed under paragraph 1 of subsection B of this section shall be reduced over a 20-year period beginning in the year after the year in which the policies are written or assumed, as provided by paragraph 5 of this subsection, no faster than:

- a. thirty-five percent (35%) of the additions in the first year succeeding the year of addition,
- b. fifteen percent (15%) of the additions in each of the succeeding two years,
- c. ten percent (10%) of the additions in the next succeeding year,
- d. three percent (3%) of the additions in the next three succeeding years,
- e. two percent (2%) of the additions in the next three succeeding years, and
- f. one percent (1%) of the additions in the next ten succeeding years.

5. The annual reductions under paragraph 4 of subsection B of this section shall be made in increments of one-fourth (1/4) of the appropriate percentage of the additions on March 31, June 30, September 30, and December 31 of each year.

C. Establishment of Reserves for the Periods After 2014.

1. In addition to the requirements imposed under this section, each domestic title insurer shall compute a total statutory premium reserve balance for all policy years combined as of December 31, 2013.

2. The balance shall be computed as if this section were in effect during the twenty-year period ending December 31, 2013. For purposes of this calculation, the balance of the reserve as of December 31, 1993, is considered to be zero.

- a. If the total minimum statutory premium reserve so calculated exceeds the aggregate amount set aside for

statutory premiums in the insurer's most recent annual statement filed with the Insurance Commissioner, the insurer shall, out of total charges for policies of title insurance, increase its statutory premium reserve by an amount equal to one-sixth (1/6) of that deficit in each of the succeeding six (6) years, beginning with calendar year 2014, until the entire deficit has been added. These added amounts (the excess reserve) shall be released in accordance with paragraph 3 of this subsection.

- b. If the total minimum statutory premium reserve so calculated is less than the aggregate amount set aside for statutory premiums in the insurer's most recent annual statement filed with the commissioner, the insurer shall release the excess amount previously set aside by an amount equal to one-sixth (1/6) of that excess in each of the succeeding six (6) years, beginning with calendar year 2014, until the entire excess has been released. The balance of the reserve (equal to the calculated minimum statutory premium reserve) shall be released in accordance with each title insurer's previous method of amortizing its statutory premium reserve.

3. The aggregate of the amounts set aside, if any, in excess of the statutory premium reserve pursuant to subparagraph a of paragraph 2 of this subsection in any calendar year as adjustments to the insurer's statutory premium reserve shall be released from the reserve and restored to net profits, or equity directly, over a period not exceeding ten (10) years pursuant to the following table:

Year of addition	Release
Year 1	Equally over ten (10) years
Year 2	Equally over nine (9) years
Year 3	Equally over eight (8) years
Year 4	Equally over seven (7) years
Year 5	Equally over six (6) years
Year 6	Equally over five (5) years

D. Companies Transitioning to five percent (5%) Statutory Premium Reserve After Calendar Year 2015.

1. Companies with annual gross premiums of less than Twenty Million Dollars (\$20,000,000.00) as of January 1, 2014, which elect to set aside reserves in an amount not less than the title insurer's IBNR reserve plus the ULAE reserve as set forth in paragraph 2 of subsection B of this section, may voluntarily transition to the five percent (5%) statutory premium reserve described elsewhere in subsection B of this section beginning in any calendar year subsequent to 2014.

2. Companies with annual gross premiums of less than Twenty Million Dollars (\$20,000,000.00) as of January 1, 2015, which have not voluntarily transitioned as set forth in subsection C of this section, but which later earn annual gross premiums of Twenty Million Dollars (\$20,000,000.00) or more, shall transition to the five percent (5%) statutory premium reserve standard beginning January 1 of the year after they earn annual gross premiums of Twenty Million Dollars (\$20,000,000.00) or more.

3. Companies transitioning to the five percent (5%) statutory premium reserve, as set forth in subsections B and C of this section, may, but need not, establish reserves for years prior to the transitional year in accordance with subsection C of this section. Alternatively, such companies may continue to use the previously established reserves for prior years until such reserves are fully amortized. Reserves established on a go-forward basis beginning with the year of transition, shall be amortized in accordance with paragraphs 4 and 5 of subsection B of this section.

E. Maintenance of Fund.

The statutory premium reserve and supplemental reserve fund shall be held in cash or invested in first mortgage notes or other securities admissible for investment by Section 5002 this title.

F. Effect of Insolvency or Dissolution.

In the event of the insolvency or dissolution of a title insurer, the statutory premium reserve and supplemental reserve fund shall be used to protect title insurance contract holders, even if there are no accrued title insurance claims and even if there are unpaid obligations of other types.

Added by Laws 2014, c. 146, § 1, eff. Nov. 1, 2014.

§36-5008. Release of mortgage affidavit.

A. As used in this section:

1. "Mortgage" means a contract lien on an interest in real property;

2. "Mortgagee" means:

- a. the grantee of a mortgage,
- b. if a mortgage has been assigned of record, the last person or entity to whom the mortgage or judgment lien has been assigned of record, or
- c. if a mortgage is serviced by a mortgage servicer, the mortgage servicer;

3. "Mortgage servicer" means the last person or entity to whom a mortgagor has been instructed by a mortgagee to send payments for the loan secured by a mortgage or judgment lien. A person or entity transmitting a payoff statement is considered the mortgage servicer for the mortgage or judgment lien described in the payoff statement;

4. "Mortgagor" means the grantor of a mortgage;

5. "Payoff statement" means a statement of the amount of:

- a. the unpaid balance of a loan secured by a mortgage or judgment lien, including principal, interest, and other charges properly assessed under the loan documentation of the mortgage or judgment lien, and
- b. interest on a per diem basis for the unpaid balance; and

6. "Title insurance company" means a corporation or other business entity authorized and licensed to transact business of insuring titles to interests in real property in this state.

B. This section applies only to a mortgage or judgment lien on all real property including commercial or agriculture or a one- to four-family residence, including a residential unit in a condominium regime.

C. If a mortgagee or judgment lienholder fails to execute and deliver a release of mortgage or judgment lien to the mortgagor or designated agent of the mortgagor within sixty (60) days after the date of receipt of payment of the mortgage by the mortgagee or judgment lienholder in accordance with a payoff statement furnished by the mortgagee or judgment lienholder or its mortgage servicer, an authorized officer of a title insurance company or a duly appointed agent of the title insurance company, on behalf of the mortgagor or a transferee of the mortgagor who acquired title to the property described in the mortgage, may execute and record an affidavit in the real property records of each county in which the mortgage or judgment lien was recorded. The written signature of the agent of the title insurance company or attorney shall appear on the affidavit. An authorized officer of a title insurance company or a duly appointed agent of the title insurance company shall not require a mortgagor or a judgment debtor to pay a fee associated with the affidavit referenced in this subsection.

D. An affidavit executed under this section shall state that:

1. The affiant is an authorized officer or a duly appointed agent of a title insurance company;

2. The affidavit is made on behalf of the mortgagor or a transferee of the mortgagor who acquired title to the property described in the mortgage;

3. The mortgagee or judgment lienholder provided a payoff statement with respect to the loan secured by the mortgage or judgment lien;

4. The affiant has ascertained that the mortgagee or judgment lienholder has received payment of the loan secured by the mortgage or judgment lien in accordance with the payoff statement, as evidenced by:

- a. a bank check, certified check, cashier's check, escrow account check from the title company or title insurance agent or attorney trust account check that

has been negotiated by the mortgagee or judgment lienholder,

b. wire transfer, or

c. another documentary evidence of the receipt of payment by the mortgagee or judgment lienholder;

5. More than sixty (60) days have elapsed since the date payment was received by the mortgagee or judgment lienholder;

6. The title insurance company or its duly appointed agent has given the mortgagee or judgment lienholder at least fifteen (15) days' notice in writing by certified mail, return receipt requested, of its intention to execute and record an affidavit in accordance with this section, with a copy of the proposed affidavit attached to the written notice; and

7. The mortgagee or judgment lienholder has not responded in writing to the notification at least fifteen (15) days before the affidavit is recorded.

E. The affidavit must include the names of the mortgagor and the mortgagee or judgment lienholder, the date of the mortgage, the legal description of the property, and the book and page or clerk's document number of the real property records where the mortgage or lien and/or modification is recorded, together with similar information for a recorded assignment of the mortgage or judgment lien.

F. The affiant shall attach to the affidavit a photostatic copy, certified by the affiant as a true copy of the original document, of:

1. The documentary evidence that payment has been received by the mortgagee or judgment lienholder, including the endorsement of the mortgagee or judgment lienholder of a negotiated check if paid by check or proof of a wire transfer if paid by wire. The bank account number and routing number on the check or proof of wire transfer may be redacted by the filer; and

2. The payoff statement.

G. An affidavit that is executed and recorded as provided by this section shall operate as a release of the mortgage or judgment lien described in the affidavit.

H. The county clerk shall index the affidavit against the real property described in the mortgage or judgment lien and the affidavit.

I. A person who knowingly causes an affidavit with false information to be executed and recorded under this section is liable for the penalties for filing a false affidavit, including the penalties for commission of offenses pursuant to the appropriate section of the penal code, and to a party injured by the affidavit for actual damages of Five Thousand Dollars (\$5,000.00), whichever is greater. The Attorney General may sue to collect the penalty. If the Attorney General or an injured party bringing suit

substantially prevails in an action under this subsection, the court may award reasonable attorney fees and court costs to the prevailing party.

J. Nothing provided for in this section shall preclude the mortgagor from availing itself of the remedies provided for in Section 15 of Title 46 of the Oklahoma Statutes which provides for penalties against the mortgagee or judgment lienholder for failure to release a mortgage or judgment lien pursuant to the payment in full and request for release on behalf of the mortgagor.

Added by Laws 2015, c. 222, § 1, eff. Nov. 1, 2015. Amended by Laws 2021, c. 249, § 1, eff. Nov. 1, 2021; Laws 2024, c. 71, § 1, eff. Nov. 1, 2024.

§36-5101. Short title.

Sections 22 through 34 of this act shall be known and may be cited as the "Reinsurance Intermediary Act".

Added by Laws 1992, c. 178, § 22, eff. Sept. 1, 1992.

§36-5102. Definitions.

As used in the Reinsurance Intermediary Act:

1. "Actuary" means a person who is a member in good standing of the American Academy of Actuaries;

2. "Controlling person" means any person, firm, association or corporation who directly or indirectly has the power to direct or cause to be directed, the management, control or activities of the reinsurance intermediary;

3. "Insurer" means any person, firm, association or corporation duly licensed in this state pursuant to the applicable provisions of the Oklahoma Insurance Code as an insurer;

4. "Licensed producer" means an agent, broker or reinsurance intermediary licensed in this state pursuant to the applicable provision of the Oklahoma Insurance Code;

5. "Reinsurance intermediary" means a reinsurance intermediary broker or a reinsurance intermediary manager as these terms are defined in this section;

6. "Reinsurance intermediary broker" (RB) means any person, other than an officer or employee of the ceding insurer, firm, association or corporation, who solicits, negotiates or places reinsurance cessions or retrocessions on behalf of a ceding insurer without the authority or power to bind reinsurance on behalf of such insurer;

7. "Reinsurance intermediary manager" (RM) means any person, firm, association or corporation that has authority to bind or manages all or part of the assumed reinsurance business of a reinsurer, including the management of a separate division, department or underwriting office, and acts as an agent for such reinsurer whether known as an RM, manager or other similar term.

The following persons shall not be considered RMs, with respect to a reinsurer, for the purposes of the Reinsurance Intermediary Act:

- a. an employee of the reinsurer,
- b. a U.S. manager of the United States branch of an alien reinsurer,
- c. an underwriting manager which, pursuant to contract, manages all the reinsurance operations of the reinsurer, is under common control with the reinsurer, subject to Article 16A of the Insurance Code, and whose compensation is not based on the volume of premiums written, or
- d. the manager of a group, association, pool or organization of insurers which engage in joint underwriting or joint reinsurance and who are subject to examination by the Insurance Commissioner of the state in which the manager's principal business office is located;

8. "Reinsurer" means any person, firm, association or corporation duly licensed in this state pursuant to the applicable provisions of the Oklahoma Insurance Code as an insurer with the authority to assume reinsurance;

9. "To be in violation" means failure by the reinsurance intermediary, insurer, reinsurer, or reinsurer for whom the reinsurance intermediary was acting to substantially comply with the provisions of the Reinsurance Intermediary Act; and

10. "Qualified United States financial institution" means an institution that:

- a. is organized or, in the case of a U.S. office of a foreign banking organization, licensed under the laws of the United States or any state thereof,
- b. is regulated, supervised and examined by U.S. federal or state authorities having regulatory authority over banks and trust companies, and
- c. has been determined by either the Commissioner, or the Securities Valuation Office of the National Association of Insurance Commissioners, to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions.

Added by Laws 1992, c. 178, § 23, eff. Sept. 1, 1992.

§36-5103. License required - Refusal to issue - Exemption.

A. No person, firm, association or corporation shall act as an RB in this state if the RB maintains an office either directly or as a member or employee of a firm or association, or an officer, director or employee of a corporation:

1. In this state, unless the RB is a licensed producer in this state; or

2. In another state, unless the RB is a licensed producer in this state or another state having a law substantially similar to this law or the RB is licensed in this state as a nonresident reinsurance intermediary.

B. No person, firm, association or corporation shall act as an RM:

1. For a reinsurer domiciled in this state, unless the RM is a licensed producer in this state;

2. In this state, if the RM maintains an office either directly or as a member or employee of a firm or association, or an officer, director or employee of a corporation in this state, unless the RM is a licensed producer in this state; or

3. In another state for a nondomestic insurer, unless the RM is a licensed producer in this state or another state having a law substantially similar to this law or the person is licensed in this state as a nonresident reinsurance intermediary.

C. The Insurance Commissioner may require an RM subject to the provisions of subsection B of this section to:

1. File a bond in an amount from an insurer acceptable to the Commissioner for the protection of the reinsurer; and

2. Maintain an errors and omissions policy in an amount acceptable to the Commissioner.

D. 1. The Commissioner may issue a reinsurance intermediary license to any person, firm, association or corporation who has complied with the requirements of the Reinsurance Intermediary Act. Any license issued to a firm or association shall authorize all the members of the firm or association and any designated employees to act as reinsurance intermediaries pursuant to the license, and all such persons shall be named in the application and any supplements thereto. Any license issued to a corporation shall authorize all of the officers, and any designated employees and directors thereof to act as reinsurance intermediaries on behalf of the corporation, and all such persons shall be named in the application and any supplements thereto.

2. If the applicant for a reinsurance intermediary license is a nonresident, the applicant, as a condition precedent to receiving or holding a license, shall designate the Commissioner as agent for service of process in the manner, and with the same legal effect, provided for by the Reinsurance Intermediary Act for designation of service of process upon surplus lines insurers; and also shall furnish the Commissioner with the name and address of a resident of this state upon whom notices or orders of the Commissioner or process affecting the nonresident reinsurance intermediary may be served. The licensee shall promptly notify the Commissioner in writing of every change in its designated agent for service of

process, and such change shall not become effective until acknowledged by the Commissioner.

E. The Commissioner may refuse to issue a reinsurance intermediary license if, in the judgment of the Commissioner, the applicant, any one named on the application, or any member, principal, officer or director of the applicant, or that any controlling person of such applicant, is not trustworthy to act as a reinsurance intermediary, or that any of the foregoing has given cause for revocation or suspension of such license, or has failed to comply with any prerequisite for the issuance of such license. Upon written request therefor, the Commissioner shall furnish a summary of the basis for refusal to issue a license, which document shall be privileged and not subject to the Oklahoma Open Records Act.

F. Licensed attorneys-at-law of this state when acting in their professional capacity as attorneys shall be exempt from this section.

G. Licenses issued by the Commissioner pursuant to this section shall be issued for a period of twenty-four (24) months. The license shall not be issued unless the application for the license is accompanied by a license fee of One Hundred Dollars (\$100.00). The license shall not be renewed unless the renewal application for the license is accompanied by a renewal fee of One Hundred Dollars (\$100.00).

Added by Laws 1992, c. 178, § 24, eff. Sept. 1, 1992. Amended by Laws 2001, c. 156, § 33, eff. Nov. 1, 2001; Laws 2010, c. 222, § 28, eff. Nov. 1, 2010.

§36-5104. Transactions to be authorized in writing - Required provisions.

Transactions between an RB and the insurer the RB represents in such capacity shall be entered into only pursuant to a written authorization, specifying the responsibilities of each party. The authorization shall, at a minimum, contain provisions that:

1. The insurer may terminate the authority of the RB at any time;

2. The RB shall render accounts to the insurer accurately detailing all material transactions, including information necessary to support all commissions, charges and other fees received by, or owing, to the RB, and remit all funds due to the insurer within thirty (30) days of receipt;

3. All funds collected for the insurer's account shall be held by the RB in a fiduciary capacity in a bank which is a qualified U.S. financial institution;

4. The RB shall comply with Section 26 of this act;

5. The RB shall comply with the written standards established by the insurer for the cession or retrocession of all risks; and

6. The RB shall disclose to the insurer any relationship with any reinsurer to which business will be ceded or retroceded.

Added by Laws 1992, c. 178, § 25, eff. Sept. 1, 1992.

§36-5105. Records of transactions.

A. For at least ten (10) years after the expiration of each contract of reinsurance transacted by an RB, the RB shall keep a complete record for each transaction showing:

1. The type of contract, limits, underwriting restrictions, classes or risks and territory;
2. Period of coverage, including effective and expiration dates, cancellation provisions and notice required of cancellation;
3. Reporting and settlement requirements of balances;
4. Rate used to compute the reinsurance premium;
5. Names and addresses of assuming reinsurers;
6. Rates of all reinsurance commissions, including, but not limited to, the commissions on any retrocessions handled by the RB;
7. Related correspondence and memoranda;
8. Proof of placement;
9. Details regarding retrocessions handled by the RB, including the identity of retrocessionaires and percentage of each contract assumed or ceded;
10. Financial records, including but not limited to, premium and loss accounts; and
11. If the RB procures a reinsurance contract on behalf of a licensed ceding insurer:
 - a. directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk, or
 - b. if placed through a representative of the assuming reinsurer, other than an employee, written evidence that such reinsurer has delegated binding authority to the representative.

B. The insurer shall have access and the right to copy and audit all accounts and records maintained by the RB related to its business in a form usable by the insurer.

Added by Laws 1992, c. 178, § 26, eff. Sept. 1, 1992.

§36-5106. Duties of insurer.

A. An insurer shall not engage the services of any person, firm, association or corporation to act as an RB on its behalf unless such person is licensed as required by the Reinsurance Intermediary Act.

B. An insurer shall not employ an individual who is employed by an RB with which the insurer transacts business, unless such RB is under common control with the insurer and subject to Article 16A of the Insurance Code.

C. The insurer annually shall obtain a copy of statements of the financial condition of each RB with which the insurer transacts business.

Added by Laws 1992, c. 178, § 27, eff. Sept. 1, 1992.

§36-5107. Contract - Minimum provisions.

Transactions between an RM and the reinsurer the RM represents in such capacity shall be entered into only pursuant to a written contract, specifying the responsibilities of each party, which shall be approved by the board of directors of the reinsurer. At least thirty (30) days before such insurer assumes or cedes business through such producer, a true copy of the approved contract shall be filed with the Commissioner for approval. The contract shall, at a minimum, contain provisions that:

1. The reinsurer may terminate the contract for cause upon written notice to the RM. The reinsurer may suspend the authority of the RM to assume or cede business during the pendency of any dispute regarding the cause for termination;

2. The RM shall render accounts to the reinsurer accurately detailing all material transactions, including information necessary to support all commissions, charges and other fees received by, or owing to the RM, and remit all funds due under the contract to the reinsurer on not less than a monthly basis;

3. All funds collected for the account of the reinsurer shall be held by the RM in a fiduciary capacity in a bank which is a qualified U.S. financial institution. The RM may retain no more than three (3) months estimated claims payments and allocated loss adjustment expenses. The RM shall maintain a separate bank account for each reinsurer that the RM represents;

4. For at least ten (10) years after expiration of each contract of reinsurance transacted by the RM, the RM shall keep a complete record for each transaction showing:

- a. the type of contract, limits, underwriting restrictions, classes or risks and territory,
- b. period of coverage, including effective and expiration dates, cancellation provisions and notice required of cancellation, and disposition of outstanding reserves on covered risks,
- c. reporting and settlement requirements of balances,
- d. rate used to compute the reinsurance premium,
- e. names and addresses of reinsurers,
- f. rates of all reinsurance commissions, including the commissions on any retrocessions handled by the RM,
- g. related correspondence and memoranda,
- h. proof of placement,
- i. details regarding retrocessions handled by the RM, as permitted by Section 30 of this act, including the

- identity of retrocessionaires and percentage of each contract assumed or ceded,
- j. financial records, including but not limited to, premium and loss accounts, and
 - k. if the RM places a reinsurance contract on behalf of a ceding insurer:
 - (1) directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk, or
 - (2) if placed through a representative of the assuming reinsurer, other than an employee, written evidence that such reinsurer has delegated binding authority to the representative;

5. The reinsurer shall have access and the right to copy all accounts and records maintained by the RM related to its business in a form usable by the reinsurer;

6. The contract shall not be assigned in whole or in part by the RM;

7. The RM shall comply with the written underwriting and rating standards established by the insurer for the acceptance, rejection, or cession of all risks;

8. Set forth the rates, terms, and purposes of commissions, charges, and other fees which the RM may levy against the reinsurer;

9. If the contract permits the RM to settle claims on behalf of the reinsurer:

- a. all claims shall be reported to the reinsurer in a timely manner,
- b. a copy of the claim file shall be sent to the reinsurer at the request of the reinsurer as soon as it becomes known that the claim:
 - (1) has the potential to exceed the lesser of an amount determined by the Commissioner or the limit set by the reinsurer,
 - (2) involves a coverage dispute,
 - (3) may exceed the claims settlement authority of the RM,
 - (4) is open for more than six (6) months, or
 - (5) is closed by payment of the lesser of an amount set by the Commissioner or an amount set by the reinsurer,
- c. all claim files shall be the joint property of the reinsurer and RM. However, upon an order of liquidation of the reinsurer such files shall become the sole property of the reinsurer or its estate. The RM shall have reasonable access to and the right to copy the files on a timely basis,

d. any settlement authority granted to the RM may be terminated for cause upon the written notice by the reinsurer to the RM or upon the termination of the contract. The reinsurer may suspend the settlement authority during the pendency of the dispute regarding the cause of termination;

10. If the contract provides for a sharing of interim profits by the RM, the interim profits shall not be paid until one (1) year after the end of each underwriting period for property business and five (5) years after the end of each underwriting period for casualty business and not until the adequacy of reserves on remaining claims has been verified pursuant to the provisions of the Reinsurance Intermediary Act;

11. The RM annually shall provide the reinsurer with a statement of the financial condition of the RM prepared by an independent certified accountant;

12. The reinsurer shall periodically, at least semi-annually, conduct an on-site review of the underwriting and claims processing operations of the RM;

13. The RM shall disclose to the reinsurer any relationship it has with any insurer prior to ceding or assuming any business with such insurer pursuant to this contract; and

14. The acts of the RM shall be deemed to be the acts of the reinsurer on whose behalf the RM is acting.

Added by Laws 1992, c. 178, § 28, eff. Sept. 1, 1992.

§36-5108. Duties of RM.

The RM shall not:

1. Bind retrocessions on behalf of the reinsurer, except that the RM may bind facultative retrocessions pursuant to obligatory facultative agreements if the contract with the reinsurer contains reinsurance underwriting guidelines for such retrocessions. Such guidelines shall include a list of reinsurers with which such automatic agreements are in effect, and for each such reinsurer, the coverages and amounts or percentages that may be reinsured, and commission schedules;

2. Commit the reinsurer to participate in reinsurance syndicates;

3. Appoint any producer without assuring that the producer is lawfully licensed to transact the type of reinsurance for which he is appointed;

4. Without prior approval of the reinsurer, pay or commit the reinsurer to pay a claim or net of retrocessions, that exceeds the lesser of an amount specified by the reinsurer or one percent (1%) of the reinsurer's policyholder's surplus as of December 31 of the last complete calendar year;

5. Collect any payment from a retrocessionaire or commit the reinsurer to any claim settlement with a retrocessionaire, without prior approval of the reinsurer. If prior approval is given, a report shall be forwarded promptly to the reinsurer;

6. Jointly employ an individual who is employed by the reinsurer; or

7. Appoint a sub-RM.

Added by Laws 1992, c. 178, § 29, eff. Sept. 1, 1992.

§36-5109. Duties of reinsurer.

A. A reinsurer shall not engage the services of any person, firm, association or corporation to act as an RM on its behalf unless such person is licensed as required by the Reinsurance Intermediary Act.

B. The reinsurer shall annually obtain a copy of statements of the financial condition of each RM which such reinsurer has engaged, prepared by an independent certified accountant in a form acceptable to the Commissioner.

C. If an RM establishes loss reserves, the reinsurer annually shall obtain the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the RM. This opinion shall be in addition to any other required loss reserve certification.

D. Binding authority for all retrocessional contracts or participation in reinsurance syndicates shall rest with an officer of the reinsurer who shall not be affiliated with the RM.

E. Within thirty (30) days of termination of a contract with an RM, the reinsurer shall provide written notification of such termination to the Commissioner.

F. A reinsurer shall not appoint to its board of directors, any officer, director, employee, controlling shareholder or subproducer of its RM. This subsection shall not apply to relationships governed by Article 16A of the Insurance Code or, if applicable, the Business Transacted with Producer Controlled Insurer Act.

Added by Laws 1992, c. 178, § 30, eff. Sept. 1, 1992.

§36-5110. Examination.

A. A reinsurance intermediary shall be subject to examination by the Commissioner. The Commissioner shall have access to all books, bank accounts and records of the reinsurance intermediary in a form usable to the Commissioner.

B. An RM may be examined as if the RM were the reinsurer.

Added by Laws 1992, c. 178, § 31, eff. Sept. 1, 1992.

§36-5111. Penalties; restitution; review.

A. A reinsurance intermediary, insurer or reinsurer found by the Insurance Commissioner, after notice and opportunity for a

hearing conducted in accordance with the Administrative Procedures Act, to be in violation of any provision of the Reinsurance Intermediary Act, shall:

1. For each separate violation, pay a penalty in an amount not exceeding Five Thousand Dollars (\$5,000.00); and

2. Be subject to revocation or suspension of license.

B. In addition, if a violation of the Reinsurance Intermediary Act is committed by a reinsurance intermediary, such reinsurance intermediary shall make restitution to the insurer, reinsurer, rehabilitator or liquidator of the insurer or reinsurer for the net losses incurred by the insurer or reinsurer attributable to such violation.

C. The decision, determination, or order of the Commissioner pursuant to this section shall be subject to judicial review pursuant to the Administrative Procedures Act.

D. Nothing contained in this section shall affect the right of the Commissioner to impose any other penalties provided in the Oklahoma Insurance Code.

E. Nothing contained in the Reinsurance Intermediary Act is intended to or shall in any manner limit or restrict the rights of policyholders, claimants, creditors, or other third parties or confer any rights to such persons.

Added by Laws 1992, c. 178, § 32, eff. Sept. 1, 1992. Amended by Laws 1997, c. 418, § 98, eff. Nov. 1, 1997.

§36-5112. Rules and regulations.

The Commissioner may promulgate and adopt reasonable rules and regulations for the implementation and administration of the provisions of the Reinsurance Intermediary Act.

Added by Laws 1992, c. 178, § 33, eff. Sept. 1, 1992.

§36-5113. Date for compliance with act.

No insurer or reinsurer shall continue to utilize the services of a reinsurance intermediary on and after September 1, 1992, unless utilization is in compliance with the provisions of the Reinsurance Intermediary Act.

Added by Laws 1992, c. 178, § 34, eff. Sept. 1, 1992.

§36-5121. Short title - Purpose - Legislative intent.

A. Sections 5121 through 5125 of this title shall be known and may be cited as the "Credit for Reinsurance Act".

B. The purpose of the Credit for Reinsurance Act is to protect the interest of insureds, claimants, ceding insurers, assuming insurers and the public generally. The Legislature hereby declares its intent is to ensure adequate regulation of insurers and reinsurers and adequate protection for those parties to whom insurers and reinsurers owe obligations. In furtherance of that

state interest, the Legislature hereby provides a mandate that upon the insolvency of a non-United States insurer or reinsurer that provides security to fund its obligations within the United States in accordance with the Credit for Reinsurance Act, the assets representing the security shall be maintained in the United States and claims shall be filed with and valued by the State Insurance Commissioner with regulatory oversight and the assets shall be distributed in accordance with the insurance laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic United States insurance companies. The Legislature declares that the matters contained in the Credit for Reinsurance Act are fundamental to the business of insurance in accordance with 15 U.S.C., Sections 1011 through 1012.

Added by Laws 1992, c. 178, § 35, eff. Sept. 1, 1992. Amended by Laws 2000, c. 169, § 1, eff. Nov. 1, 2000.

§36-5122. Requirements for allowance of credit.

A. Credit for reinsurance shall be allowed a domestic ceding insurer as either an asset or a reduction from liability on account of reinsurance ceded only when the reinsurer meets the requirements of subsection B, C, D, E, F, G or H of this section; provided, further, that the Commissioner may adopt by regulation pursuant to subsection B of Section 5124 of this title, specific additional requirements relating to or setting forth the valuation of assets or reserve credits, the amount and forms of security supporting reinsurance arrangements described in subsection B of Section 5124 of this title and the circumstances pursuant to which credit will be reduced or eliminated. Credit shall be allowed under subsection B, C or D of this section only as respects cessions of those kinds or classes of business in which the assuming insurer is licensed or otherwise permitted to write or assume in its state of domicile or, in the case of a United States branch of an alien assuming insurer, in the state through which it is entered and licensed to transact insurance or reinsurance. Credit shall be allowed under subsection D or E of this section only if the applicable requirements of subsection I have been satisfied.

B. Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is licensed to transact insurance or reinsurance in this state.

C. Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is accredited by the Insurance Commissioner as a reinsurer in this state. An accredited reinsurer is one that:

1. Files with the Insurance Commissioner evidence of its submission to this state's jurisdiction;
2. Submits to this state's authority to examine its books and records;

3. Is licensed to transact insurance or reinsurance in at least one state, or in the case of a United States branch of an alien assuming insurer is entered through and licensed to transact insurance or reinsurance in at least one state;

4. Files annually with the Insurance Commissioner a copy of its annual statement filed with the insurance department of its state of domicile and a copy of its most recent audited financial statement; and

5. Demonstrates to the satisfaction of the Insurance Commissioner that it has adequate financial capacity to meet its reinsurance obligations and is otherwise qualified to assume reinsurance from domestic insurers. An assuming insurer is deemed to meet this requirement as of the time of its application if it maintains a surplus as regards policyholders in an amount not less than Twenty Million Dollars (\$20,000,000.00) and its accreditation has not been denied by the Insurance Commissioner within ninety (90) days after submission of its application.

D. Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is domiciled in, or in the case of a United States branch of an alien assuming insurer is entered through, a state that employs standards regarding credit for reinsurance substantially similar to those applicable under this statute and the assuming insurer or United States branch of an alien assuming insurer:

1. Maintains a surplus as regards policyholders in an amount not less than Twenty Million Dollars (\$20,000,000.00); and

2. Submits to the authority of this state to examine its books and records.

The requirement of paragraph 1 of this subsection does not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system.

E. 1. Credit shall be allowed when the reinsurance is ceded to an assuming insurer that maintains a trust fund in a qualified United States financial institution, as defined in Section 5123.1 of this title, for the payment of the valid claims of its United States ceding insurers, their assigns and successors in interest. To enable the Insurance Commissioner to determine the sufficiency of the trust fund, the assuming insurer shall report annually to the Insurance Commissioner information substantially the same as that required to be reported on the National Association of Insurance Commissioners Annual Statement form by licensed insurers. The assuming insurer shall submit to examination of its books and records by the Commissioner and bear the expense of examination.

2. Credit for reinsurance shall not be granted under this subsection unless the form of the trust and any amendments to the trust have been approved by:

- a. the Commissioner of the state where the trust is domiciled, or
- b. the Commissioner of another state who, pursuant to the terms of the trust instrument, has accepted principal regulatory oversight of the trust.

3. The form of the trust and any trust amendments also shall be filed with the Insurance Commissioner of every state in which the ceding insurer beneficiaries of the trust are domiciled. The trust instrument shall provide that contested claims shall be valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust shall vest legal title to its assets in its trustees for the benefit of the assuming insurer's United States ceding insurers, their assigns and successors in interest. The trust and the assuming insurer shall be subject to examination as determined by the Insurance Commissioner.

4. The trust shall remain in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust.

5. No later than February 28 of each year the trustee of the trust shall report to the Insurance Commissioner in writing the balance of the trust and listing the trust's investments at the preceding year end and shall certify the date of termination of the trust, if so planned, or certify that the trust shall not expire prior to the following December 31.

6. The following requirements apply to the following categories of assuming insurer:

- a. the trust fund for a single assuming insurer shall consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers, and, in addition, the assuming insurer shall maintain a trusteed surplus of not less than Twenty Million Dollars (\$20,000,000.00), except as provided in subparagraph b of this paragraph,
- b. at any time after the assuming insurer has permanently discontinued underwriting new business secured by the trust for at least three (3) full years, the Commissioner with principal regulatory oversight of the trust may authorize a reduction in the required trusteed surplus, but only after a finding, based on an assessment of the risk, that the new required surplus level is adequate for the protection of United States ceding insurers, policyholders and claimants in light of reasonably foreseeable adverse loss development. The risk assessment may involve an actuarial review including an independent analysis of reserves and cash flows, and shall consider all

material risk factors including when applicable the lines of business involved, the stability of the incurred loss estimates and the effect of the surplus requirements on the assuming insurer's liquidity or solvency. The minimum required trusteed surplus shall not be reduced to an amount less than thirty percent (30%) of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers covered by the trust,

- c. (1) in the case of a group including incorporated and individual unincorporated underwriters:
 - (a) for reinsurance ceded under reinsurance agreements with an inception, amendment, or renewal date on or after January 1, 1993, the trust shall consist of a trusteed account in an amount not less than the respective underwriters' several liabilities attributable to business ceded by United States-domiciled ceding insurers to any underwriter of the group,
 - (b) for reinsurance ceded under reinsurance agreements with an inception date on or before December 31, 1992, and not amended or renewed after that date, notwithstanding the other provisions of the Credit for Reinsurance Act, the trust shall consist of a trusteed account in an amount not less than the respective underwriters' several insurance and reinsurance liabilities attributable to business written in the United States, and
 - (c) in addition to these trusts, the group shall maintain in trust a trusteed surplus of which One Hundred Million Dollars (\$100,000,000.00) shall be held jointly for the benefit of the United States-domiciled ceding insurers of any member of the group for all years of account,
- (2) the incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of regulation and solvency control by the group's domiciliary regulator as are the unincorporated members, and
- (3) within ninety (90) days after its financial statements are due to be filed with the group's domiciliary regulator, the group shall provide to

the Commissioner an annual certification by the group's domiciliary regulator of the solvency of each underwriter member; or if a certification is unavailable, financial statements, prepared by independent public accountants, of each underwriter member of the group, and

- d. in the case of a group of incorporated underwriters under common administration, the group shall:
 - (1) have continuously transacted an insurance business outside the United States for at least three (3) years immediately prior to making application for accreditation,
 - (2) maintain aggregate policyholders' surplus of at least Ten Billion Dollars (\$10,000,000,000.00),
 - (3) maintain a trust fund in an amount not less than the group's several liabilities attributable to business ceded by United States-domiciled ceding insurers to any member of the group pursuant to reinsurance contracts issued in the name of the group,
 - (4) in addition, maintain a joint trusteed surplus of which One Hundred Million Dollars (\$100,000,000.00) shall be held jointly for the benefit of United States-domiciled ceding insurers of any member of the group as additional security for these liabilities, and
 - (5) within ninety (90) days after its financial statements are due to be filed with the group's domiciliary regulator, make available to the Commissioner an annual certification of each underwriter member's solvency by the member's domiciliary regulator and financial statements of each underwriter member of the group prepared by its independent public accountant.

F. Credit shall be allowed when the reinsurance is ceded to an assuming insurer that has been certified by the Commissioner as a reinsurer in this state and secures its obligations in accordance with the requirements of this subsection.

1. In order to be eligible for certification, the assuming insurer shall meet the following requirements:

- a. the assuming insurer shall be domiciled and licensed to transact insurance or reinsurance in a qualified jurisdiction, as determined by the Commissioner pursuant to paragraph 3 of this subsection,
- b. the assuming insurer shall maintain minimum capital and surplus, or its equivalent, in an amount to be determined by the Commissioner pursuant to regulation,

- c. the assuming insurer shall maintain financial strength ratings from two or more rating agencies deemed acceptable by the Commissioner pursuant to regulation,
- d. the assuming insurer shall agree to submit to the jurisdiction of this state, appoint the Commissioner as its agent for service of process in this state and agree to provide security for one hundred percent (100%) of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers if it resists enforcement of a final United States judgment,
- e. the assuming insurer shall agree to meet applicable information filing requirements as determined by the Commissioner, both with respect to an initial application for certification and on an ongoing basis, and
- f. the assuming insurer shall satisfy any other requirements for certification deemed relevant by the Commissioner.

2. An association including incorporated and individual unincorporated underwriters, may be a certified reinsurer. In order to be eligible for certification, in addition to satisfying requirements of paragraph 1 of this subsection:

- a. the association shall satisfy its minimum capital and surplus requirements through the capital and surplus equivalents (net of liabilities) of the association and its members, which shall include a joint central fund that may be applied to any unsatisfied obligation of the association or any of its members, in an amount determined by the Commissioner to provide adequate protection,
- b. the incorporated members of the association shall not be engaged in any business other than underwriting as a member of the association and shall be subject to the same level of regulation and solvency control by the association's domiciliary regulator as are the unincorporated members, and
- c. within ninety (90) days after its financial statements are due to be filed with the association's domiciliary regulator, the association shall provide to the Commissioner an annual certification by the association's domiciliary regulator of the solvency of each underwriter member; or if a certification is unavailable, financial statements, prepared by independent public accountants, of each underwriter member of the association.

3. The Commissioner shall create and publish a list of qualified jurisdictions under which an assuming insurer licensed and domiciled in such jurisdiction is eligible to be considered for certification by the Commissioner as a certified reinsurer.

- a. In order to determine whether the domiciliary jurisdiction of a non-United-States assuming insurer is eligible to be recognized as a qualified jurisdiction, the Commissioner shall evaluate the appropriateness and effectiveness of the reinsurance supervisory system of the jurisdiction, both initially and on an ongoing basis, and consider the rights, benefits and the extent of reciprocal recognition afforded by the non-United-States jurisdiction to reinsurers licensed and domiciled in the United States. A qualified jurisdiction shall agree to share information and cooperate with the Commissioner with respect to all certified reinsurers domiciled within that jurisdiction. A jurisdiction shall not be recognized as a qualified jurisdiction if the Commissioner has determined that the jurisdiction does not adequately and promptly enforce final United States judgments and arbitration awards. Additional factors may be considered in the discretion of the Commissioner.
- b. A list of qualified jurisdictions shall be published through the National Association of Insurance Commissioners (NAIC) Committee Process. The Commissioner shall consider this list in determining qualified jurisdictions. If the Commissioner approves a jurisdiction as qualified that does not appear on the list of qualified jurisdictions, the Commissioner shall provide thoroughly documented justification in accordance with criteria to be developed under regulations.
- c. United States jurisdictions that meet the requirement for accreditation under the NAIC financial standards and accreditation program shall be recognized as qualified jurisdictions.
- d. If a certified reinsurer's domiciliary jurisdiction ceases to be a qualified jurisdiction, the Commissioner may at his or her discretion suspend the reinsurer's certification indefinitely, in lieu of revocation.

4. The Commissioner shall assign a rating to each certified reinsurer, giving due consideration to the financial strength ratings that have been assigned by rating agencies deemed acceptable

to the Commissioner pursuant to regulation. The Commissioner shall publish a list of all certified reinsurers and their ratings.

5. A certified reinsurer shall secure obligations assumed from United States ceding insurers under this subsection at a level consistent with its rating, as specified in regulations promulgated by the Commissioner.

- a. In order for a domestic ceding insurer to qualify for full financial statement credit for reinsurance ceded to a certified reinsurer, the certified reinsurer shall maintain security in a form acceptable to the Commissioner and consistent with the provisions of Section 5123 of this title, or in a multibeneficiary trust in accordance with subsection E of this section, except as otherwise provided in this subsection.
- b. If a certified reinsurer maintains a trust to fully secure its obligations subject to subsection E of this section, and chooses to secure its obligations incurred as a certified reinsurer in the form of a multibeneficiary trust, the certified reinsurer shall maintain separate trust accounts for its obligations incurred under reinsurance agreements issued or renewed as a certified reinsurer with reduced security as permitted by this subsection or comparable laws of other United States jurisdictions and for its obligations subject to subsection E of this section. It shall be a condition to the grant of certification under this subsection that the certified reinsurer shall have bound itself, by the language of the trust and agreement with the Commissioner with principal regulatory oversight of each such trust account, to fund, upon termination of any such trust account, out of the remaining surplus of such trust any deficiency of any other such trust account.
- c. The minimum trusteed surplus requirements provided in subsection E of this section are not applicable with respect to a multibeneficiary trust maintained by a certified reinsurer for the purpose of securing obligations incurred under this subsection, except that such trust shall maintain a minimum trusteed surplus of Ten Million Dollars (\$10,000,000.00).
- d. With respect to obligations incurred by a certified reinsurer under this subsection, if the security is insufficient, the Commissioner shall reduce the allowable credit by an amount proportionate to the deficiency, and may at his or her discretion impose further reductions in allowable credit upon finding that there is a material risk that the certified

reinsurer's obligations will not be paid in full when due.

6. If an applicant for certification has been certified as a reinsurer in an NAIC-accredited jurisdiction, the Commissioner may at his or her discretion defer to that jurisdiction's certification, and may in his or her discretion defer to the rating assigned by that jurisdiction, and such assuming insurer shall be considered to be a certified reinsurer in this state.

7. A certified reinsurer that ceases to assume new business in this state may request to maintain its certification in inactive status in order to continue to qualify for a reduction in security for its in-force business. An inactive certified reinsurer shall continue to comply with all applicable requirements of this subsection, and the Commissioner shall assign a rating that takes into account, if relevant, the reasons why the reinsurer is not assuming new business.

8. For purposes of this subsection:

- a. a certified reinsurer whose certification has been terminated for any reason shall be treated as a certified reinsurer required to secure one hundred percent (100%) of its obligations, and
- b. the term "terminated" refers to revocation, suspension, voluntary surrender and inactive status. If the Commissioner continues to assign a higher rating as permitted by this section, the requirement to secure one hundred percent (100%) of its obligations shall not apply to a certified reinsurer in inactive status or to a reinsurer whose certification has been suspended.

G. 1. Credit shall be allowed when the reinsurance is ceded to an assuming insurer meeting all of the following conditions:

- a. the assuming insurer shall have its head office or be domiciled, as applicable, and licensed in a reciprocal jurisdiction. For purposes of this subparagraph, "reciprocal jurisdiction" is a jurisdiction that is one of the following:
 - (1) a non-United States jurisdiction that is subject to an in-force, covered agreement with the United States, each within its legal authority, or, in the case of a covered agreement between the United States and the European Union, is a member state of the European Union. For purposes of this subparagraph, a "covered agreement" is an agreement entered into pursuant to Dodd-Frank Wall Street Reform and Consumer Protection Act, 31 U.S.C. Sections 313 and 314, that is currently in effect or in a period of provisional

- application and addresses the elimination, under specified conditions, of collateral requirements as a condition for entering into any reinsurance agreement with a ceding insurer domiciled in this state or for allowing the ceding insurer to recognize credit for reinsurance,
- (2) a United States jurisdiction that meets the requirements for accreditation under the National Association of Insurance Commissioners financial standards and accreditation program, or
 - (3) a qualified jurisdiction, as determined by the Commissioner pursuant to paragraph 3 of subsection F of this section, that is not otherwise described in division 1 or 2 of subparagraph a of paragraph 1 of this subsection and meets additional requirements consistent with the terms and conditions of in-force, covered agreements, as specified by the Commissioner in rules,
- b. the assuming insurer shall have and maintain, on an ongoing basis, minimum capital and surplus, or its equivalent, calculated according to the methodology of its domiciliary jurisdiction, in an amount to be set forth in Insurance Department rules. If the assuming insurer is an association including incorporated and individual unincorporated underwriters, it shall have and maintain, on an ongoing basis, minimum capital and surplus equivalents (net of liabilities), calculated according to the methodology applicable in its domiciliary jurisdiction, and a central fund containing a balance in amounts to be set forth in Department rules,
 - c. the assuming insurer shall have and maintain, on an ongoing basis, a minimum solvency or capital ratio, as applicable, which will be set forth in Department rules. If the assuming insurer is an association including incorporated and individual unincorporated underwriters, it shall have and maintain, on an ongoing basis, a minimum solvency or capital ratio in the reciprocal jurisdiction where the assuming insurer has its head office or is domiciled and is also licensed,
 - d. the assuming insurer shall agree and provide adequate assurance to the Insurance Commissioner, in a form specified by the Commissioner, as follows:
 - (1) the assuming insurer shall provide prompt written notice and explanation to the Commissioner if it

- falls below the minimum requirements set forth in subparagraph b or c of this paragraph, or if any regulatory action is taken against it for serious noncompliance with applicable law,
- (2) the assuming insurer shall consent in writing to the jurisdiction of the courts of this state and to the appointment of the Commissioner as agent for service of process. The Commissioner may require that consent for service of process be provided to the Commissioner and included in each reinsurance agreement. Nothing in this provision shall be construed to limit, or in any way alter, the capacity of parties to a reinsurance agreement to agree to alternative dispute resolution mechanisms, except to the extent such agreements are unenforceable under applicable insolvency or delinquency laws,
 - (3) the assuming insurer shall consent in writing to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer or its legal successor, that have been declared enforceable in the jurisdiction where the judgment was obtained,
 - (4) each reinsurance agreement shall include a provision requiring the assuming insurer to provide security in an amount equal to one hundred percent (100%) of the liabilities of the assuming insurer attributable to reinsurance ceded pursuant to that agreement if the assuming insurer resists enforcement of a final judgment that is enforceable under the law of the jurisdiction in which it was obtained or a properly enforceable arbitration award, whether obtained by the ceding insurer or by its legal successor on behalf of its resolution estate, and
 - (5) the assuming insurer shall confirm that it is not presently participating in any solvent scheme of arrangement that involves the ceding insurers of this state, and agree to notify the ceding insurer and the Commissioner and to provide security in an amount equal to one hundred percent (100%) of the liabilities of the assuming insurer to the ceding insurer, should the assuming insurer enter into such a solvent scheme of arrangement. The security shall be in a form consistent with the provisions of subsection F of Section 5122 and Section 5123 of this title, specified by the Commissioner in rule,

- e. the assuming insurer or its legal successor shall provide, on behalf of itself and any legal predecessors, any additional documentation requested by the Commissioner in regulation,
- f. the assuming insurer shall maintain a practice of prompt payment of claims under reinsurance agreements, pursuant to criteria set forth in rule,
- g. the supervisory authority of the assuming insurer shall confirm to the Commissioner on an annual basis, as of the preceding December 31 or at the annual date otherwise statutorily reported to the reciprocal jurisdiction, that the assuming insurer complies with the requirements set forth in subparagraphs b and c of this paragraph, and
- h. nothing in this provision shall be construed to preclude an assuming insurer from providing the Commissioner with information on a voluntary basis.

2. The Commissioner shall timely create and publish a list of reciprocal jurisdictions.

- a. A list of reciprocal jurisdictions is published through the National Association of Insurance Commissioners Committee Process. The list shall include any reciprocal jurisdiction as defined under subparagraph a of paragraph 1 of this subsection and shall consider any other reciprocal jurisdiction included on the National Association of Insurance Commissioners list. The Commissioner may approve a jurisdiction that does not appear on the list of reciprocal jurisdictions in accordance with criteria to be developed through rules issued by the Commissioner.
- b. The Commissioner may remove a jurisdiction from the list of reciprocal jurisdictions upon a determination that the jurisdiction no longer meets the requirements of a reciprocal jurisdiction, in accordance with a process set forth in rules issued by the Commissioner, except that the Commissioner shall not remove from the list a reciprocal jurisdiction as defined under subparagraph a of paragraph 1 of this subsection. Upon removal of a reciprocal jurisdiction from this list, credit for reinsurance ceded to an assuming insurer that has its home office or is domiciled in that jurisdiction shall be allowed, if otherwise allowed pursuant to this act.

3. The Commissioner shall timely create and publish a list of assuming insurers that have satisfied the conditions set forth in this subsection and to which cessions shall be granted credit in

accordance with this subsection. The Commissioner may add an assuming insurer to such list if a National Association of Insurance Commissioners accredited jurisdiction has added the assuming insurer to a list of such assuming insurers or if, upon initial eligibility, the assuming insurer submits the information to the Commissioner as required under subparagraph d of paragraph 1 of this subsection and complies with any additional requirements that the Commissioner may impose by regulation, except to the extent that they conflict with an applicable covered agreement.

4. If the Commissioner determines that an assuming insurer no longer meets one or more of the requirements under this subsection, the Commissioner may revoke or suspend the eligibility of the assuming insurer for recognition under this subsection in accordance with procedures set forth in Department rules.

- a. While the eligibility of an assuming insurer is suspended, no reinsurance agreement issued, amended or renewed after the effective date of the suspension qualifies for credit except to the extent that the obligations of the assuming insurer under the contract are secured in accordance with the provisions of Section 5123 of this title.
- b. If the eligibility of an assuming insurer is revoked, no credit for reinsurance may be granted after the effective date of the revocation with respect to any reinsurance agreements entered into by the assuming insurer including reinsurance agreements entered into prior to the date of revocation, except to the extent that the obligations of the assuming insurer under the contract are secured in a form acceptable to the Commissioner.

5. If subject to a legal process of rehabilitation, liquidation or conservation, as applicable, the ceding insurer or its representative may seek and, if determined appropriate by the court in which the proceedings are pending, may obtain an order requiring that the assuming insurer post security for all outstanding ceded liabilities.

6. Nothing in this subsection shall be construed to limit or in any way alter the capacity of parties to a reinsurance agreement to agree on requirements for security or other terms in that reinsurance agreement, except as expressly prohibited by this act or other applicable law or rule.

7. Credit may be taken under this subsection only for reinsurance agreements entered into, amended or renewed on or after the effective date of this act, and only with respect to losses incurred and reserves reported on or after the later of (1) the date on which the assuming insurer has met all eligibility requirements

pursuant to paragraph 1 of this subsection, and (2) the effective date of the new reinsurance agreement, amendment or renewal.

- a. This paragraph does not alter or impair the right of a ceding insurer to take credit for reinsurance, to the extent that credit is not available under this subsection, as long as the reinsurance qualifies for credit under any other applicable provision of this act.
- b. Nothing in this subsection shall be construed to authorize an assuming insurer to withdraw or reduce the security provided under any reinsurance agreement, except as permitted by the terms of the agreement.
- c. Nothing in this subsection shall be construed to limit, or in any way alter, the capacity of parties to any reinsurance agreement to renegotiate the agreement.

H. Credit shall be allowed when the reinsurance is ceded to an assuming insurer not meeting the requirements of subsection B, C, D, E, F or G of this section but only as the insurance of risks located in jurisdictions where the reinsurance is required by applicable law or regulation of that jurisdiction.

I. If the assuming insurer is not licensed, accredited or certified to transact insurance or reinsurance in this state, the credit permitted by subsections D and E of this section shall not be allowed unless the assuming insurer agrees in the reinsurance agreements:

1. That in the event of the failure of the assuming insurer to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, shall submit to the jurisdiction of any court of competent jurisdiction in any state of the United States, will comply with all requirements necessary to give the court jurisdiction, and will abide by the final decision of the court or of any appellate court in the event of an appeal; and

2. To designate the Insurance Commissioner or a designated attorney as its true and lawful attorney upon whom may be served any lawful process in any action, suit or proceeding instituted by or on behalf of the ceding insurer. This subsection is not intended to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes, if this obligation is created in the agreement.

J. If the assuming insurer does not meet the requirements of subsection B, C, D, or G of this section, the credit permitted by subsection E or F of this section shall not be allowed unless the assuming insurer agrees in the trust agreements to the following conditions:

1. Notwithstanding any other provisions in the trust instrument, if the trust fund is inadequate because it contains an amount less than the amount required by paragraph 6 of subsection E of this section, or if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation or similar proceedings under the laws of its state or country of domicile, the trustee shall comply with an order of the Commissioner with regulatory oversight over the trust or with an order of a court of competent jurisdiction directing the trustee to transfer to the Commissioner with regulatory oversight all of the assets of the trust fund;

2. The assets shall be distributed by and claims shall be filed with and valued by the Commissioner with regulatory oversight in accordance with the laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic insurance companies;

3. If the Commissioner with regulatory oversight determines that the assets of the trust fund or any part thereof are not necessary to satisfy the claims of the United States ceding insurers of the grantor of the trust, the assets or part thereof shall be returned by the Commissioner with regulatory oversight to the trustee for distribution in accordance with the trust agreement; and

4. The grantor shall waive any right otherwise available to it under United States law that is inconsistent with this provision.

K. If an accredited or certified reinsurer ceases to meet the requirements for accreditation or certification, the Commissioner may suspend or revoke the reinsurer's accreditation or certification.

1. The Commissioner shall give the reinsurer notice and opportunity for hearing. The suspension or revocation shall not take effect until after the Commissioner's order on hearing, unless:

- a. the reinsurer waives its right to hearing,
- b. the Commissioner's order is based on regulatory action by the reinsurer's domiciliary jurisdiction or the voluntary surrender or termination of the reinsurer's eligibility to transact insurance or reinsurance business in its domiciliary jurisdiction or in the primary certifying state of the reinsurer under paragraph 6 of subsection F of this section, or
- c. the Commissioner finds that an emergency requires immediate action and a court of competent jurisdiction has not stayed the Commissioner's action.

2. While a reinsurer's accreditation or certification is suspended, no reinsurance contract issued or renewed after the effective date of the suspension qualifies for credit except to the extent that the reinsurer's obligations under the contract are secured in accordance with Section 5123 of this title. If a

reinsurer's accreditation or certification is revoked, no credit for reinsurance shall be granted after the effective date of the revocation except to the extent that the reinsurer's obligations under the contract are secured in accordance with paragraph 5 of subsection F of this section or Section 5123 of this title.

L. Concentration Risk.

1. A ceding insurer shall take steps to manage its reinsurance recoverables proportionate to its own book of business. A domestic ceding insurer shall notify the Commissioner within thirty (30) days after reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers, exceeds fifty percent (50%) of the domestic ceding insurer's last reported surplus to policyholders, or after it is determined that reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers, is likely to exceed this limit. The notification shall demonstrate that the exposure is safely managed by the domestic ceding insurer.

2. A ceding insurer shall take steps to diversify its reinsurance program. A domestic ceding insurer shall notify the Commissioner within thirty (30) days after ceding to any single assuming insurer, or group of affiliated assuming insurers, more than twenty percent (20%) of the ceding insurer's gross written premium in the prior calendar year, or after it has determined that the reinsurance ceded to any single assuming insurer, or group of affiliated assuming insurers, is likely to exceed this limit. The notification shall demonstrate that the exposure is safely managed by the domestic ceding insurer.

Added by Laws 1992, c. 178, § 36, eff. Sept. 1, 1992. Amended by Laws 1994, c. 86, § 1, eff. Sept. 1, 1994; Laws 1997, c. 418, § 99, eff. Nov. 1, 1997; Laws 2000, c. 169, § 2, eff. Nov. 1, 2000; Laws 2016, c. 298, § 1, eff. Nov. 1, 2016; Laws 2021, c. 47, § 1, eff. Nov. 1, 2021; Laws 2022, c. 154, § 5, eff. Nov. 1, 2022.

§36-5123. Asset or reduction from liability for ceded reinsurance - Security

An asset or a reduction from liability for the reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of Section 5122 of this title shall be allowed in an amount not exceeding the liabilities carried by the ceding insurer; provided, further, that the Commissioner may adopt by regulation pursuant to subsection B of Section 5124 of this title, specific additional requirements relating to or setting forth: the valuation of assets or reserve credits, the amount and forms of security supporting reinsurance arrangements described in subsection B of Section 5124 of this title and the circumstances pursuant to which credit will be reduced or eliminated. The reduction shall be in the amount of funds held by or on behalf of the ceding insurer including

funds held in trust for the ceding insurer, under a reinsurance contract with the assuming insurer as security for the payment of obligations thereunder, if the security is held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer; or, in the case of a trust, held in a qualified United States financial institution, as defined in subsection B of Section 5123.1 of this title. This security may be in the form of:

1. Cash;
2. Securities listed by the Securities Valuation Office of the National Association of Insurance Commissioners including those deemed exempt from filing as defined by the Purposes and Procedures Manual of the Securities Valuation Office and qualifying as admitted assets;
3.
 - a. Clean, irrevocable, unconditional letters of credit, issued or confirmed by a qualified United States financial institution, as defined in subsection A of Section 5123.1 of this title, effective no later than December 31 of the year for which the filing is being made, and in the possession of, or in trust for, the ceding insurer on or before the filing date of its annual statement.
 - b. Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance or confirmation shall, notwithstanding the issuing or confirming institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification or amendment, whichever first occurs; or
4. Any other form of security acceptable to the Insurance Commissioner.

Added by Laws 1992, c. 178, § 37, eff. Sept. 1, 1992. Amended by Laws 1995, c. 52, § 1, emerg. eff. April 10, 1995; Laws 2000, c. 169, § 3, eff. Nov. 1, 2000; Laws 2002, c. 307, § 33, eff. Nov. 1, 2002; Laws 2016, c. 298, § 2, eff. Nov. 1, 2016; Laws 2022, c. 154, § 6, eff. Nov. 1, 2022.

§36-5123.1. Qualified United States financial institution defined

A. For purposes of paragraph 3 of Section 5123 of Title 36 of the Oklahoma Statutes, a "qualified United States financial institution" means an institution that:

1. Is organized or, in case of a United States office of a foreign banking organization, licensed under the laws of the United States or any state thereof;
2. Is regulated, supervised and examined by United States federal or state authorities having regulatory authority over banks and trust companies; and

3. Has been determined by either the Insurance Commissioner or the Securities Valuation Office of the National Association of Insurance Commissioners to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the Commissioner.

B. For purposes of the provisions of the Credit for Reinsurance Act specifying those institutions that are eligible to act as a fiduciary of a trust, a "qualified United States financial institution" means an institution that:

1. Is organized or, in the case of a United States branch or agency office of a foreign banking organization, licensed under the laws of the United States or any state thereof and has been granted authority to operate with fiduciary powers; and

2. Is regulated, supervised and examined by federal or state authorities having regulatory authority over banks and trust companies.

Added by Laws 2016, c. 298, § 3, eff. Nov. 1, 2016.

§36-5124. Rules and regulations.

A. The Insurance Commissioner may promulgate and adopt rules and regulations implementing the provisions of the Credit for Reinsurance Act.

B. The Insurance Commissioner is further authorized to adopt rules and regulations applicable to reinsurance arrangements described in paragraph 1 of this subsection.

1. A regulation adopted pursuant to this subsection may apply only to reinsurance relating to:

- a. life insurance policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits,
- b. universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period,
- c. variable annuities with guaranteed death or living benefits,
- d. long-term care insurance policies, or
- e. such other life and health insurance and annuity products as to which the National Association of Insurance Commissioners (NAIC) adopts model regulatory requirements with respect to credit for reinsurance.

2. A regulation adopted pursuant to this subsection which is applicable to policies listed in subparagraph a or b of paragraph 1 of this subsection may apply to any treaty containing:

- a. policies issued on or after January 1, 2015, and
- b. policies issued prior to January 1, 2015, if risk pertaining to such pre-2015 policies is ceded in connection with the treaty, in whole or in part, on or

after January 1, 2015, unless the NAIC Accounting Practices and Procedures Manual in effect as of December 31, 2015, excluded such pre-2015 policies from the requirements concerning the amounts and forms of security supporting reinsurance arrangements that would otherwise be applicable to such policies.

3. A regulation adopted pursuant to this subsection may require the ceding insurer, in calculating the amounts or forms of security required to be held under regulations promulgated under this authority, to use the Valuation Manual adopted by the NAIC under Section 11B (1) of the NAIC Standard Valuation Law including all amendments adopted by the NAIC and in effect on the date as of which the calculation is made, to the extent applicable.

4. A regulation adopted pursuant to this subsection shall not apply to cessions to an assuming insurer that:

- a. meets the conditions set forth in subsection G of Section 5122 of this title,
- b. is certified in this state, or
- c. maintains at least Two Hundred Fifty Million Dollars (\$250,000,000.00) in capital and surplus when determined in accordance with the NAIC Accounting Practices and Procedures Manual including all amendments thereto adopted by the NAIC, excluding the impact of any permitted or prescribed practices, and is:
 - (1) licensed in at least twenty-six states, or
 - (2) licensed in at least ten states, and licensed or accredited in a total of at least thirty-five states.

5. The authority to adopt regulations pursuant to this subsection does not limit the Commissioner's general authority to adopt regulations pursuant to subsection A of this section.

Added by Laws 1992, c. 178, § 38, eff. Sept. 1, 1992. Amended by Laws 2016, c. 298, § 4, eff. Nov. 1, 2016; Laws 2021, c. 47, § 2, eff. Nov. 1, 2021; Laws 2022, c. 154, § 7, eff. Nov. 1, 2022.

NOTE: Editorially renumbered from § 5123 of this title to avoid duplication in numbering.

§36-5125. Repealed by Laws 2016, c. 298, § 5, eff. Nov. 1, 2016.

§36-6001. Discrimination through fictitious grouping prohibited.

No insurer, admitted or nonadmitted, shall make available through any rating plan or form, property, marine, vehicle, casualty or surety insurance to any firm, corporation, or association of individuals, any preferred rate or premium based upon any fictitious grouping of such firm, corporation or association of individuals. Laws 1959, p. 135, § 1, emerg. eff. May 8, 1959.

§36-6001.1. Conditions under which groups not considered fictitious.

A group or combination of persons or risks shall not be considered a fictitious group if the conditions provided in this section are met:

1. The group shall have been in existence for at least two (2) years prior to the purchase of the intended group plan of insurance or conclusive proof submitted to the Insurance Commissioner that such group was not organized primarily for the purpose of purchasing insurance;

2. The group shall have a highly reasonable degree of homogeneity;

3. Eligible members of the group shall be persons in good standing in the group. In the case of employees, such employees should be engaged in active employment of the employer of the group for not less than thirty (30) hours each week, or shall be on a pension with that respective employer or be the surviving spouse of a deceased pensioner;

4. Group underwriting standards shall be applied consistently throughout the group;

5. Coverage shall be available to all eligible members and the individual members of their family, who are members of their immediate household; but no prospective employee or employee already employed shall be required to participate as a condition of employment;

6. The experience of other similar groups within the state and insured by the same carrier shall not be combined for the purpose of determining rates;

7. Policies issued to members of such groups shall provide no more restrictive insuring agreements and conditions than those of policies available to the individual purchaser from the same insurer, and such groups shall be provided with the option to select a policy with such limits of coverage as are available to individual purchasers from the same insurer;

8. Any insurer offering such a group plan shall also be required to provide insurance on an individual basis to the general public of the state and shall not be permitted to enter in this state an insurance company solely for the purpose of mass marketing or grouping of auto insurance policies for any group;

9. The insurer shall be required to offer to a member a conversion to a standard plan of insurance offered by the same insurer to the general public of the state in which the group operates in the event of separation of the member from the group through termination of employment for any reason;

10. Individual policies of insurance shall be issued to each member of the group and the premiums shall be paid to the insurer

periodically by the group or member, with or without payroll deductions; and

11. With regard to automobile insurance, unless the insurance for the entire group is canceled concurrently, no policy of insurance issued to a member shall be canceled except as otherwise provided by law.

Added by Laws 1996, c. 70, § 1, eff. Nov. 1, 1996.

§36-6002. Approval by Insurance Commissioner.

No form or plan of insurance covering any group or combination of persons or risks shall be written or delivered within or outside of this state to cover Oklahoma persons or risks at any preferred rate or form other than that offered to persons not in such group, and the public generally, unless such form, plan or policy and the rates or premiums to be charged therefor have been submitted to and filed or approved by the Insurance Commissioner.

Added by Laws 1959, p. 135, § 2, emerg. eff. May 8, 1959. Amended by Laws 1997, c. 418, § 100, eff. Nov. 1, 1997; Laws 2006, c. 264, § 62, eff. July 1, 2006.

§36-6003. Exceptions.

Nothing in this Act shall apply to life, accident, health and hospitalization policies or annuity contracts.

Laws 1959, p. 136, § 3, emerg. eff. May 8, 1959.

§36-6011. Application to Oklahoma Employees Health Insurance Plan.

A. Any mandated health insurance coverage signed into law after November 1, 2016, for specific health services, benefits, diseases, copay structure, formulary structure or for certain providers of health care services shall also apply to the Oklahoma Employees Health Insurance Plan.

B. As used in this section, "Oklahoma Employees Health Insurance Plan" shall have the same meaning as "health insurance plan" as defined in Section 1303 of Title 74 of the Oklahoma Statutes.

Added by Laws 2016, c. 92, § 1, eff. Nov. 1, 2016.

§36-6012. Participation in premium assistance program - Recognition of self-funded or self-insured health care plans.

The Insurance Department shall recognize self-funded or self-insured health care plans for the exclusive purpose of participation in the premium assistance program created under Section 1010.1 of Title 56 of the Oklahoma Statutes if such plans meet the requirements under subsection J of Section 1010.1 of Title 56 of the Oklahoma Statutes. A self-funded or self-insured health care plan recognized by the Department under this section shall only be considered a health care plan for the exclusive purposes of the

premium assistance program created under Section 1010.1 of Title 56 of the Oklahoma Statutes.

Added by Laws 2022, c. 309, § 1, eff. Nov. 1, 2022. Amended by Laws 2024, c. 133, § 1, eff. July 1, 2024.

§36-6031. Report of holdings and change in ownership - Unfair use of information - Recovery of profits.

A. Every person who is directly or indirectly the beneficial owner of more than ten per cent (10%) of any class of equity security of an insurer or who is a director or officer of such insurer shall file in the office of the Insurance Commissioner within (10) ten days after becoming such beneficial owner, director or officer a statement, in such form and detail and subject to such rules as the Insurance Commissioner may prescribe, of the amount of all equity securities of such insurer of which he or she is the beneficial owner, director or officer within ten (10) days after the close of each calendar month thereafter, if there has been a change in such ownership during such month, shall file in the office of the Insurance Commissioner a statement, in such form and detail and subject to such rules as the Insurance Commissioner may prescribe, indicating his or her ownership at the close of the calendar month and such changes in his or her ownership as have occurred during such calendar month.

B. For the purpose of preventing the unfair use of information which may have been obtained by such beneficial owner, director or officer by reason of his or her relationship to such insurer, any profit realized by him or her from any purchase and sale or any sale and purchase, of any equity security of such insurer within any period of less than two (2) years subsequent to the incorporation of the insurer, shall inure to and be recoverable by the insurer, unless such equity security was acquired in good faith in connection with a debt previously contracted, irrespective of any intention on the part of such beneficial owner, director or officer in entering into such transaction.

C. Suit to recover such profit may be instituted at law or in equity in any court of competent jurisdiction by the insurer or by the owner of any equity security of the insurer in the name and in behalf of the insurer if the insurer shall fail or refuse to bring such suit within sixty (60) days after request or shall fail diligently to prosecute the same thereafter. If no suit to recover such profit is so filed within six (6) months following the date such profit was realized or accrued or if at any time such suit is not diligently prosecuted, the Insurance Commissioner may file or prosecute such suit for and on behalf of the insurer at the expense of the insurer.

Added by Laws 1965, c. 341, § 1, emerg. eff. June 28, 1965. Amended by Laws 1997, c. 418, § 101, eff. Nov. 1, 1997.

§36-6032. Limitation on sales of equity securities of certain domestic life insurance companies.

A. Not more than forty-nine percent (49%) of the equity securities of any insurer shall be sold to any person, firm, corporation or trustee or nominee thereof where said insurer has been organized within two (2) years preceding the acquisition of such equity securities, unless the stock so sold or acquired shall have been at a price not less than the highest market value of such stock during two (2) years subsequent to incorporation or the highest price at which such stock is offered to the public during two (2) years subsequent to incorporation, whichever sum is the greater. Should more than forty-nine percent (49%) of the equity securities of any insurer be sold to any person, firm, corporation or trustee or nominee thereof at a price less than the highest market price or the highest price such stock is offered to the public during the first two (2) years subsequent to incorporation, such excess between the purchase price and such highest market or highest offering price shall inure to and be recoverable by the insurer, unless such equity security was acquired in good faith in connection with a debt previously contracted, irrespective of any intention on the part of such purchaser in entering into such transaction.

B. Suit to recover such profit may be instituted at law or in equity in any court of competent jurisdiction by the insurer or by the owner of any equity security of the insurer in the name of and in behalf of the insurer if the insurer shall fail or refuse to bring suit within sixty (60) days after request or shall fail to diligently prosecute the same thereafter. If no suit to recover the difference between the purchase price and such highest market or highest offered price is filed within six (6) months after the realization of such profit or after the expiration of two (2) years subsequent to the incorporation of the insurer, or if at any time such suit is not diligently prosecuted, the Insurance Commissioner may file or prosecute such suit for and on behalf of the insurer at the expense of the insurer.

C. If the Insurance Commissioner shall find from substantial evidence submitted that for the best interest of the policyholders or creditors of an insurer the Commissioner should approve some plan of merger, consolidation, rehabilitation or sale of such insurer but is prevented or hindered from doing so because of the provisions of this section, the Commissioner may order that said transaction be exempt from the provisions of this section.

Added by Laws 1965, c. 341, § 2, emerg. eff. June 28, 1965. Amended by Laws 1997, c. 418, § 102, eff. Nov. 1, 1997.

§36-6033. Limitation on compensation, fees or commissions.

It shall be unlawful for any person, firm, or corporation to pay or to receive more than fifteen per cent (15%) of the price received or paid for the equity security of any insurer as compensation for services, fees or commissions related directly or indirectly to the organization and promotion of the insurer and for the issuance or sale of the equity security of the insurer. In addition to any other penalty which may be applicable thereto, either under the Insurance Code or otherwise, violation of this section shall constitute a misdemeanor and shall be punishable as such where no greater penalty is provided therefor. In addition thereto, any person, firm or corporation that pays or receives in excess of the said fifteen per cent (15%) for such purposes shall be liable to the insurer for an amount double such excess. Suit to recover such excess may be instituted at law or in equity in any court of competent jurisdiction by the insurer or by the owner of any equity security of the insurer in the name and in behalf of the insurer if the insurer shall fail or refuse to bring such suit within sixty days after request or shall fail diligently to prosecute the same thereafter. If no suit to recover such profit is so filed within six months following the date such profit was realized or accrued or if at any time such suit is not diligently prosecuted, the Insurance Commissioner may file or prosecute such suit for and on behalf of the insurer at the expense of the insurer.

Laws 1965, c. 341, § 3, emerg. eff. June 28, 1965.

§36-6034. Sale or transfer of securities issued under incentive, bonus or stock option plans.

After the effective date of this act, no equity securities issued by any domestic life insurance company, under any incentive, bonus, "stock option" or similar plan, and no rights to acquire any such equity securities shall, within a period of two (2) years after the date of original allotment by the issuer thereof be sold, or be transferred for value, or be exchanged, for a consideration exceeding one hundred fifteen percent (115%) of the net proceeds received by the issuer thereof for such securities or rights at the time of allotment, provided, however, that the limitations in this section set forth shall not be applicable to any such securities or rights originally issued or allotted at a price or value equal to the market price of such securities or rights on the date of issue or allotment, or to any such securities or rights allotted or issued by the issuer thereof for eighty-five percent (85%) or more of the price or value at which such securities or rights were offered by such issuer to the public on the date of allotment or issue thereof, whichever is the greater, or to any such securities or rights which were deposited and held in escrow for at least two (2) years from date of issue or allotment in compliance with a rule promulgated or an order issued by the Administrator, Oklahoma Securities

Commission, under the Oklahoma Uniform Securities Act of 2004. It shall be unlawful for any person to sell, transfer or exchange any such equity securities in contravention of this section.

Added by Laws 1965, c. 341, § 4, emerg. eff. June 28, 1965. Amended by Laws 2022, c. 77, § 3, eff. Nov. 1, 2022.

§36-6035. Enforcement of act - Definitions.

This act shall be administered and enforced by the Insurance Commissioner. The term "insurer" when used in this act means any domestic life insurance company during the first two (2) years of its existence and the provisions hereof are applicable to any such insurer and to any person, firm or corporation that holds, sells or deals in equity securities or options therefor of any domestic life insurance company during the first two years of existence or prior thereto. Provided, however, the provisions of this act shall not apply after a period of two (2) years subsequent to the latest registration for public offering under the Oklahoma Uniform Securities Act of 2004. The term "equity securities" when used herein includes options therefor. This act applies to domestic life insurance companies during the first two (2) years of existence and to every person, firm or corporation that holds, sells, or deals in equity securities, or options therefor, of any domestic life insurance company during the first two (2) years of the existence of a domestic life insurance company or prior thereto or which engages in the formation, organization or promotion of a domestic life insurance company.

Added by Laws 1965, c. 341, § 5, emerg. eff. June 28, 1965. Amended by Laws 2022, c. 77, § 4, eff. Nov. 1, 2022.

§36-6036. Construction.

This act shall be construed as an independent act. This act shall be construed as cumulative with and supplemental to other laws and acts now in effect or enacted hereafter.

Laws 1965, c. 341, § 6, emerg. eff. June 28, 1965.

§36-6041. Payments - How made.

Payment or each periodic payment not exceeding One Thousand Dollars (\$1,000.00) for emergency living expenses made to any policyholder or his or her dependents or beneficiaries under an insurance policy for:

1. Fire insurance;
2. Casualty insurance;
3. Property insurance, including what may be termed a homeowner's policy; or
4. Any other type of policy that insures against personal loss as a consequence of loss of or damage to real or personal property; which provides for payment or periodic payments for emergency living

expenses; and payments made under workers' compensation or employers' liability insurance as defined in Section 707 of this title, shall be made through the use of United States legal tender, or through a means acceptable to the recipient of the payment including, but not limited to, electronic funds transfer, prepaid cards, negotiable instruments payable on demand or negotiable drafts.

Added by Laws 1981, c. 230, § 1, emerg. eff. June 22, 1981. Amended by Laws 2015, c. 298, § 12, eff. Nov. 1, 2015.

§36-6045. Reimbursement for mental or behavioral health or alcohol or drug treatment services.

Notwithstanding any provision of any individual or group policy, contract, plan or agreement of accident and/or health insurance or any provisions of a policy, contract, plan or agreement for hospital or medical service or indemnity, whenever such policy, contract, plan or agreement provides for reimbursement for any mental or behavioral health or alcohol and drug treatment service which is within the lawful scope of practice of a duly licensed physician, physician assistant, licensed clinical social worker, licensed professional counselor, licensed marriage and family therapist, licensed alcohol and drug counselor, licensed behavioral practitioner, licensed psychologist, or advance practice registered nurse, the person entitled to benefits, or the person performing services, under such policy, contract, plan or agreement shall be entitled to reimbursement on an equitable basis for such service at a rate commensurate with the requirements for their licensure.

Added by Laws 2008, c. 165, § 1, eff. Nov. 1, 2008.

§36-6050. Prepaid or discounted ambulance service membership subscriptions.

All persons, companies, governmental entities or trust authorities operating an ambulance service within this state may sell prepaid or discounted ambulance service membership subscriptions to individuals who reside within its authorized service area in exchange for payment of an annual membership fee. The agreement between the ambulance service and an individual shall not be deemed to be insurance and shall expressly provide for the assignment of insurance benefits directly to the ambulance service. Under such assignment, the insurer shall be obligated directly to the ambulance service for the lesser of the full and customary charge by the ambulance service or the designated or allowable amount set forth by the insurance policy for any services actually rendered to the individual by the ambulance service during the membership year less any applicable deductible or copayment.

Added by Laws 2002, c. 307, § 34, eff. Nov. 1, 2002.

§36-6050.1. Short title – Out-of-Network Ambulance Service Provider Act.

This act shall be known and may be cited as the "Out-of-Network Ambulance Service Provider Act".

Added by Laws 2024, c. 356, § 1, eff. Jan. 1, 2025.

§36-6050.2. Definitions.

As used in the Out-of-Network Ambulance Service Provider Act:

1. "Ambulance service provider" means an ambulance service as defined by Section 1-2503 of Title 63 of the Oklahoma Statutes except that, for the purposes of this act, the term shall be limited to an ambulance service provider that provides ground transportation services;

2. "Covered ambulance services" means those ground ambulance services which an enrollee is entitled to receive under the terms of a health care benefit plan;

3. "Enrollee" means a person who is entitled to receive covered ambulance services under the terms of a health care benefit plan;

4. "Health care benefit plan" means a plan, policy, contract, certificate, agreement, or other evidence of coverage for health care services offered, issued, renewed, or extended in this state by a health care insurer, or government-sponsored self-insured plans. Health care benefit plan does not include any health plan offered by a contracted entity as defined in Section 4002.2 of Title 56 of the Oklahoma Statutes that provides coverage to members of the state Medicaid program;

5. "Health care insurer" means an entity that is subject to state insurance regulation and provides coverage for health benefits in this state and includes the following:

- a. an insurance company,
- b. a health maintenance organization,
- c. a hospital and medical service corporation,
- d. a risk-based provider organization, or
- e. a sponsor or self-funded plan.

Health care insurer does not include a contracted entity as defined in Section 4002.2 of Title 56 of the Oklahoma Statutes that provides coverage to members of the state Medicaid program;

6. "Out-of-network" means a provider that does not contract with the health care insurer of the enrollee receiving the covered ambulance services; and

7. "Clean claim" means a claim that has no defect of impropriety, including any lack of required substantiating documentation or particular circumstances requiring special treatment that prevents timely payment from being made on the claim.

Added by Laws 2024, c. 356, § 2, eff. Jan. 1, 2025.

§36-6050.3. Minimum reimbursement rate set by local governmental entity – Default rate – Payment.

A. The minimum allowable reimbursement rate under any health care benefit plan issued by a health care insurer to an out-of-network ambulance service provider for providing covered ambulance services shall be at the rates set or approved, whether in contract or ordinance, by a local governmental entity in the jurisdiction in which the covered ambulance services originate.

B. In the absence of the rates as provided in subsection A of this section, the rate shall be the lesser of:

1. Three hundred twenty-five percent (325%) of the current published rate for ambulance services as established by the Centers for Medicare and Medicaid Services under Title XVIII of the Social Security Act for the same services provided in the same geographic area; or

2. The ambulance service provider's billed charges.

C. Payment made in compliance with this section shall be considered payment in full for the covered ambulance services provided, except for any copayment, coinsurance, deductible, and other cost-sharing feature amounts required to be paid by the enrollee. An ambulance service provider is prohibited from billing the enrollee for any additional amounts for the paid covered ambulance services in excess of what the health care insurer pays.

D. All copayments, coinsurance, deductible, and other cost-sharing feature amounts provided by subsection A of this section shall not exceed the in-network copayment, coinsurance, deductible, and other cost-sharing features for the covered ambulance services received by the enrollee.

E. In administering and paying claims, a health care insurer shall comply with Section 1219 of Title 36 of the Oklahoma Statutes. Added by Laws 2024, c. 356, § 3, eff. Jan. 1, 2025.

§36-6051. Free choice of practitioner and profession - Equal reimbursement.

Notwithstanding any provision of any individual or group policy, contract, plan or agreement of accident and/or health insurance or any provisions of a policy, contract, plan or agreement for hospital or medical service or indemnity, whenever such policy, contract, plan or agreement provides for reimbursement for any visual or optometric service which is within the lawful scope of practice of a duly licensed optometrist, the person entitled to benefits, or person performing services, under such policy, contract, plan or agreement shall be entitled to reimbursement on an equal basis for such service, whether the said service is performed by a physician licensed under 59 O.S.1961, Sections 481 through 518, inclusive, or by an optometrist licensed under 59 O.S.1961, Sections 581 through 606, inclusive. Optometric services shall include eye and/or visual

examination or a correction of any vision or muscular anomaly and the supplying of ophthalmic materials, including contact lenses and subnormal vision aids. Unless such policy, contract, plan or agreement shall otherwise provide, there shall be no reimbursement for ophthalmic materials, lenses, contact lenses, spectacles, eyeglasses, and/or appurtenances thereto.

Laws 1967, c. 17, § 1, emerg. eff. Feb. 21, 1967.

§36-6052. Copayment requirements - Disclosure of calculations - Penalty - Rules.

A. Any policy, contract or agreement issued or renewed by an insurer, as defined in Section 6054 of Title 36 of the Oklahoma Statutes, or any contract or agreement issued or renewed for any preferred provider or other provider arrangement or managed care plan, which requires the insured or enrollee to make a copayment when benefits are provided, shall disclose to the insured or enrollee the calculation for the copayment. In no case shall the copayment be based on a higher figure than either the amount billed or the amount paid, whichever is less. This subsection shall apply to any health insurance plan offered through the State and Education Employees Group Insurance Act.

B. Any insurer, hospital or licensed health care provider determined to be in violation of subsection A of this section by the Insurance Commissioner, the State Board of Health or the appropriate health care professional licensing entity, after notice, shall be subject to an administrative fine of not less than One Thousand Dollars (\$1,000.00) or more than Five Thousand Dollars (\$5,000.00) for each violation. Notice under this section shall include a statement of violations on which the fine is based and notice of the opportunity for a hearing.

C. The Insurance Commissioner, the State Board of Health or the appropriate health care professional licensing entity shall promulgate rules providing for enforcement of the provisions of this act. In addition, each entity may promulgate rules providing for suspension or revocation of a license for substantial failure to comply with the provisions of this act. Such rules shall provide for notice and a hearing prior to the suspension or revocation of a license.

Added by Laws 1996, c. 335, § 1, eff. Nov. 1, 1996.

§36-6053. Short title and application.

A. Sections 6053 through 6057 of this title and Sections 6 through 9 of this act shall be known and may be cited as the "Health Care Freedom of Choice Act".

B. The provisions of the Health Care Freedom of Choice Act shall not apply to contracts executed with a preferred provider organization to provide health care services for employer-sponsored

self-funded plans covered by the federal Employee Retirement Income Security Act (ERISA).

Added by Laws 1994, c. 342, § 18, eff. Sept. 1, 1994. Amended by Laws 1999, c. 331, § 1, eff. Nov. 1, 1999.

§36-6054. Definitions.

As used in the Health Care Freedom of Choice Act:

1. "Accident and health insurance policy" or "policy" means any policy, certificate, contract, agreement or other instrument that provides accident and health insurance, as defined in Section 703 of this title, to any person in this state;

2. "Ambulatory surgical center" means any ambulatory surgery facility licensed by the State Department of Health as defined in Section 2657 of Title 63 of the Oklahoma Statutes;

3. "Home care agency" means any sole proprietorship, partnership, association, corporation, or other organization which administers, offers, or provides home care services, for a fee or pursuant to a contract for such services, to clients in their place of residence. The term "home care agency" shall not include an individual who contracts with the Department of Human Services to provide personal care services; provided, such individual shall not be exempt from certification as a home health aide;

4. "Hospital" means any facility as defined in Section 1-701 of Title 63 of the Oklahoma Statutes;

5. "Insured" means any person entitled to reimbursement for expenses of health care services and procedures under an accident and health insurance policy issued by an insurer;

6. "Insurer" means any entity that provides an accident and health insurance policy in this state, including but not limited to a licensed insurance company, a not-for-profit hospital service and medical indemnity corporation, a fraternal benefit society, a multiple employer welfare arrangement, or any other entity subject to regulation by the Insurance Commissioner;

7. "Practitioner" means any person holding a valid license to practice medicine and surgery, osteopathic medicine, chiropractic, podiatric medicine, optometry or dentistry, pursuant to the state licensing provisions of Title 59 of the Oklahoma Statutes; and

8. "Preferred provider organization (PPO)" means a network of practitioners, hospitals, home care agencies or ambulatory surgical centers, which have entered into a contract with an insurer to provide health care services under the terms and conditions established in the contract.

Added by Laws 1989, c. 37, § 1, eff. Nov. 1, 1989. Amended by Laws 1994, c. 342, § 19, eff. Sept. 1, 1994; Laws 1996, c. 76, § 1, eff. Nov. 1, 1996; Laws 1999, c. 331, § 2, eff. Nov. 1, 1999.

§36-6055. Performance of services and procedures by practitioners - Freedom of choice - Exclusions - Compensation of practitioners - Decisions to authorize or deny emergency services.

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.

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, ambulatory surgical centers, home care agencies, or other health care providers or facilities that are licensed or certified by the state who are participating preferred provider organization providers and practitioners, hospitals, ambulatory surgical centers, home care agencies, or other health care providers or facilities that are licensed or certified by the state 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, and
- 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.

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, ambulatory surgical center, home care agency, or other health care provider or facility that is licensed or certified by the state that is not a preferred provider shall disclose to the insured, in writing, that the insured may be responsible for:

- a. higher coinsurance and deductibles, and
- b. practitioner, hospital or ambulatory surgical center charges which exceed the allowable charges of a preferred provider, and
- c. a good-faith estimate of the total cost to the insured.

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.

E. Upon submission of a claim by a practitioner, hospital, home care agency, ambulatory surgical center, or other health care provider or facility that is licensed or certified by the state 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, ambulatory surgical center, or other health care provider or facility that is licensed or certified by the state regardless of the network participation status of such person or entity.

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, ambulatory surgical center, or other health care provider or facility that is licensed or certified by the state who has provided services and procedures which are covered under the policy. A practitioner, hospital, home care agency, ambulatory surgical center, or other health care provider or facility that is licensed or certified by the state 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, ambulatory surgical center, or other health care provider or facility that is licensed or certified by the state;

2. A copy of the assignment has been provided by the practitioner, hospital, home care agency, ambulatory surgical center, or other health care provider or facility that is licensed or certified by the state to the insurer;

3. A claim has been submitted by the practitioner, hospital, home care agency, ambulatory surgical center, or other health care provider or facility that is licensed or certified by the state 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 and the estimate required in subparagraph c of paragraph 1 of subsection D of this section have been provided by the practitioner, hospital, home care agency, ambulatory surgical center, or other health care provider or facility that is licensed or certified by the state to the insured.

G. The provisions of subsection F 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, ambulatory surgical center, or other health care provider or facility that is licensed or

- certified by the state 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, ambulatory surgical center, or other health care provider or facility that is licensed or certified by the state, except a practitioner who has a prior felony conviction, to become a network provider if the 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.

The provisions of this section shall not be deemed to prohibit a policyholder from assigning benefits available pursuant to an accident and health insurance policy, provided that the benefits of such policy include out-of-network provisions and are being assigned to an out-of-network practitioner, hospital, home care agency, ambulatory surgical center, or other health care provider or facility that is licensed or certified by the state. The assignability of an accident and health insurance policy related to out-of-network care shall only be subject to the terms and conditions specified in subsection F of this section.

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.

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.

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.

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.

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.

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.

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.

O. Nothing in the Health Care Freedom of Choice Act shall be construed as prohibiting an insurer, preferred provider organization or other network from determining the adequacy of the size of its network.

P. An insurer or a preferred provider organization shall not unilaterally remove a provider from the network solely because the provider informs an enrollee of the full range of physicians and providers available to the enrollee including out-of-network providers. Nothing in the Health Care Freedom of Choice Act prohibits any insurer from allowing a contract to expire by its own terms or negotiating a new contract with the provider at the end of the contract term. A provider agreement shall not, as a condition of the agreement, prohibit, penalize, terminate, or otherwise restrict a preferred provider from referring to an out-of-network

provider; provided, the insured signs an acknowledgment of referral that the insured may be responsible for:

1. Higher coinsurance and deductibles; and
2. Charges which exceed the allowable charges of a preferred provider.

Added by Laws 1971, c. 183, § 5. Amended by Laws 1984, c. 26, § 1, emerg. eff. March 22, 1984; Laws 1986, c. 251, § 43, eff. Nov. 1, 1986; Laws 1989, c. 37, § 2, eff. Nov. 1, 1989; Laws 1992, c. 370, § 2, eff. Sept. 1, 1992; Laws 1995, c. 356, § 1, eff. Nov. 1, 1995; Laws 1996, c. 76, § 2, eff. Nov. 1, 1996; Laws 1999, c. 331, § 3, eff. Nov. 1, 1999; Laws 2000, c. 127, § 1, eff. Nov. 1, 2000; Laws 2000, c. 350, § 1, eff. Nov. 1, 2000; Laws 2003, c. 288, § 2, eff. Nov. 1, 2003; Laws 2009, c. 176, § 36, eff. Nov. 1, 2009; Laws 2021, c. 217, § 1, eff. Nov. 1, 2021; Laws 2023, c. 158, § 2, eff. Nov. 1, 2023.

§36-6056. Place where services may be performed.

Services and procedures covered under an accident and health insurance policy may be performed at any hospital, home care agency or ambulatory surgical center where a practitioner is authorized to practice, doctor's office or clinic, at the choice of the insured, or the insured's parent or guardian if the insured is a minor, and the practitioner who is providing the services and procedures.

Added by Laws 1971, c. 183, § 6. Amended by Laws 1989, c. 37, § 3, eff. Nov. 1, 1989; Laws 1996, c. 76, § 3, eff. Nov. 1, 1996; Laws 1999, c. 331, § 4, eff. Nov. 1, 1999.

§36-6057. Denial under policy coverage as void - Compliance with act.

A. Any provision, exclusion or limitation in an accident and health insurance policy which:

1. Denies an insured, or the insured's parent or guardian if the insured is a minor, the free choice of any practitioner or the use of any hospital, home care agency or ambulatory surgical center where the practitioner is authorized to practice, doctor's office or clinic; or

2. Otherwise conflicts with any provision of the Health Care Freedom of Choice Act, shall, to the extent of the denial or conflict, be void, but such avoidance shall not affect the validity of the other provisions of the policy.

B. Any policy form presently approved for use containing any provision, exclusion or limitation determined by the Insurance Commissioner to be in conflict with any provision of the Health Care Freedom of Choice Act shall be brought into compliance with the act by the filing of a rider, an endorsement, or a new or revised policy form approved by the Commissioner.

Added by Laws 1971, c. 183, § 7. Amended by Laws 1989, c. 37, § 4, eff. Nov. 1, 1989; Laws 1996, c. 76, § 4, eff. Nov. 1, 1996; Laws 1999, c. 331, § 5, eff. Nov. 1, 1999.

§36-6057.1. Examination and enforcement by Commissioner - Attorneys' fees.

A. In order to enforce the provisions of the Health Care Freedom of Choice Act, the Insurance Commissioner may conduct an examination of insurers' and preferred provider organizations' claims files pursuant to the procedure set forth in Section 1250.4 of this title.

B. The Commissioner, upon finding an insurer in violation of any provision of the Health Care Freedom of Choice Act, may issue a cease and desist order to the insurer directing the insurer to stop such unlawful practices. If the insurer refuses or fails to comply with the order, the Commissioner shall have the authority to revoke or suspend the insurer's certificate of authority. The Commissioner shall use the authority specified in this subsection to the extent deemed necessary to obtain the insurer's compliance with the order. The Attorney General shall offer assistance if requested by the Commissioner to enforce the Commissioner's orders.

C. Reasonable attorney fees shall be awarded to the Commissioner if judicial action is necessary for the enforcement of the orders. Such fees shall be based upon those prevailing in the community. Fees collected by the Commissioner without the assistance of the Attorney General shall be credited to the Insurance Commissioner's Revolving Fund. Fees collected by the Attorney General shall be credited to the Attorney General's Revolving Fund.

Added by Laws 1999, c. 331, § 6, eff. Nov. 1, 1999. Amended by Laws 2000, c. 353, § 43, eff. Nov. 1, 2000.

§36-6057.2. Penalties.

For any violation of the Health Care Freedom of Choice Act, the Insurance Commissioner may, after notice and opportunity hearing, subject an insurer or practitioner to an administrative penalty of not less than One Hundred Dollars (\$100.00) nor more than Five Thousand Dollars (\$5,000.00) for each occurrence. Such administrative penalty may be enforced in the same manner in which civil judgments may be enforced. The penalties collected shall be placed in the Insurance Commissioner's Revolving Fund.

Added by Laws 1999, c. 331, § 7, eff. Nov. 1, 1999.

§36-6057.3. Judicial review.

Any insurer or practitioner affected by an order of the Insurance Commissioner issued pursuant to the Health Care Freedom of

Choice Act may seek judicial review of such order pursuant to Article II of the Administrative Procedures Act.
Added by Laws 1999, c. 331, § 8, eff. Nov. 1, 1999.

§36-6057.4. Rules.

The Insurance Commissioner shall promulgate rules for the implementation and administration of the Health Care Freedom of Choice Act.

Added by Laws 1999, c. 331, § 9, eff. Nov. 1, 1999.

§36-6057.5. Surgical Patient Choice Task Force - Appointment of members - Meetings - Reimbursement of travel expenses - Recommendations and report.

A. There is hereby created to continue until February 1, 2006, the Surgical Patient Choice Task Force.

1. The Task Force shall consist of ten (10) members.

2. Of the ten members:

a. three shall be appointed by the Speaker of the Oklahoma House of Representatives as follows:

(1) one shall be a representative of a health insurer which owns or operates a statewide provider network,

(2) one shall represent a specialty hospital, and

(3) one shall be a member of the Oklahoma House of Representatives and shall serve as cochair,

b. three shall be appointed by the President Pro Tempore of the State Senate as follows:

(1) one shall represent an ambulatory surgical center,

(2) one shall represent a statewide hospital association, and

(3) one shall be a member of the State Senate and shall serve as cochair,

c. two shall be appointed by the Governor as follows:

(1) one shall be a representative of a full-service community hospital located in a community with a population of over three hundred thousand (300,000), and

(2) one shall represent a hospital located in a rural area, and

d. two shall be public sector representatives or their designees as follows:

(1) the Commissioner of the State Department of Health, and

(2) the Insurance Commissioner.

B. 1. Appointed members of the Task Force shall serve at the pleasure of their appointing authority.

2. A vacancy on the Task Force shall be filled by the original appointing authority.

3. Appointments to the Task Force shall be made by August 1, 2005.

C. 1. A majority of the members present at a meeting shall constitute a quorum to do business.

2. The cochairs of the Task Force shall convene the first meeting of the Task Force on or before September 1, 2005, at which time a schedule of the meetings shall be determined.

3. The Oklahoma Insurance Department shall provide staff support for the Task Force.

D. The Task Force may divide into subcommittees in furtherance of its purposes.

E. Members of the Task Force shall receive no compensation but shall be reimbursed for necessary travel expenses incurred in the performance of their duties pursuant to the provisions of the State Travel Reimbursement Act as follows:

1. Legislative members of the Task Force shall be reimbursed in accordance with the provisions of Section 456 of Title 74 of the Oklahoma Statutes; and

2. Nonlegislative members of the Task Force shall be reimbursed by their appointing authorities.

F. The purpose of the Task Force shall be to make recommendations to the Legislature and the Governor regarding ways to improve patient access to rural hospitals, specialty hospitals and ambulatory surgical centers by:

1. Studying the issue of the exclusion of hospitals including specialty hospitals and ambulatory surgical centers from health insurance plans when those facilities are willing to meet the terms of a contract set forth and offered to similar providers by health insurance companies;

2. Determining whether a need exists to expand opportunities for hospitals to participate in health insurance provider networks;

3. Determining if patients have the ability to choose among and between all geographically relevant providers which meet requirements set by insurance companies;

4. Determining if providers as defined in this act who are not allowed to participate in provider networks are denied participation based on issues related to patient safety, sound economic policies, and the practice of medicine;

5. Making recommendations as to the role of the State Insurance Commission and the State Department of Health in establishing a system of appeal when a hospital, specialty hospital, or ambulatory surgical center, is denied participation in a provider network; and

6. Identifying other issues deemed appropriate by the Task Force.

G. The Task Force shall issue a report of its recommendations to the Legislature and Governor no later than January 1, 2006.
Added by Laws 2005, c. 81, § 1, emerg. eff. April 19, 2005.

§36-6058. Newly-born children - Health insurance benefits.

A. All individual and group health insurance policies providing coverage on an expense incurred, fixed, or capitated basis, and all individual and group insurance policies, certificates, service or indemnity type contracts issued by insurance companies, health maintenance organizations, nonprofit corporations, or charitable and benevolent corporations established for the purpose of operating a nonprofit hospital service, indemnity, fixed or capitated plan, or a nonprofit medical or indemnity plan, and all self-insurers which provide coverage for a family member of the insured or subscriber shall, as to such family member's coverage, also provide that the health insurance benefits applicable for children shall be payable with respect to a newly born child of the insured or subscriber from the moment of birth.

B. The coverage for newly born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Such coverage shall also include transportation necessary for the provision of medical care for such newly born children when (1) the newly born is transported to the nearest hospital capable of providing the medically necessary treatment on a timely basis, and (2) the mode of transportation is the most economical consistent with the well-being of the newly born. Transportation coverage shall not exceed the reasonable costs of providing such service and an itemized statement of costs shall accompany each claim.

The provisions of this subsection shall not apply to policies involving Medicare and supplements to Medicare.

C. If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth and payment of the required premium or fees must be furnished to the insurer or nonprofit service or indemnity corporation within thirty-one (31) days after the date of birth in order to have the coverage continue beyond such thirty-one-day period.

Added by Laws 1975, c. 87, § 1, operative Sept. 1, 1975. Amended by Laws 1984, c. 129, § 1, eff. July 1, 1985; Laws 2006, c. 264, § 63, eff. July 1, 2006.

§36-6058A. Enrollment of child under parent's health plan - Noncustodial parents.

A. Notwithstanding any other provision of law, an insurer shall not deny enrollment of a child under the health plan of the child's parent on the grounds that:

1. The child was born out of wedlock;
2. The child is not claimed as a dependent on the parent's federal income tax return; or
3. The child does not reside with the parent or in the insurer's service area.

B. If a child has health coverage through an insurer of a noncustodial parent the insurer shall:

1. Upon request, provide complete information to the custodial person, the designated agency administering the State Medicaid Program, the state agency administering the provisions of 42 U.S.C., Sections 5 through 669, or the Child Support Enforcement Division of the Department of Human Services, regarding any insurance benefits to which the child is entitled, and any forms, publications, or documents necessary to apply for or to utilize the benefits available through that coverage;

2. Permit the custodial person, the designated agency administering the State Medicaid Program, or the provider with approval, to submit claims for covered services without the approval of the noncustodial parent; and

3. Make payments on claims submitted in accordance with paragraph 2 of this subsection directly to the custodial person, the provider, or the designated agency administering the State Medicaid Program.

C. When a parent is required by a court or administrative order to provide health coverage for a child, and the parent is eligible for family health coverage, the insurer shall be required:

1. To permit the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions;

2. To enroll the child under family coverage and deduct the employee's cost of the coverage from the employee's wages. The enrollment shall be made upon application to the employer by the custodial person, the designated agency administering the State Medicaid Program, or the state agency administering the provisions of 42 U.S.C., Sections 5 to 669, the Child Support Enforcement Division; and

3. Not to disenroll, or eliminate coverage for the child unless the insurer is provided satisfactory written evidence that:

- a. the court or administrative order is no longer in effect, or
- b. the child is or will be enrolled in comparable health coverage through another insurer which will take effect not later than the effective date of disenrollment;

provided, however, the provisions of this subsection shall not apply where the coverage is through a group plan and the group's coverage through the insurer is discontinued or the noncustodial parent ceases to be eligible for participation in the group plan.

D. An insurer may not impose requirements on a state agency, which has been assigned the rights of an individual eligible for medical assistance under Medicaid and covered for health benefits from the insurer, that are different from requirements applicable to an agent or assignee of any other individual covered.

E. As used in this section, "insurer" includes a licensed insurance company, not-for-profit hospital service or medical indemnity corporation, a fraternal benefit society, a health maintenance organization, a prepaid plan, a preferred provider organization, a multiple employer welfare arrangement, a self-insured, the State and Education Employees Group Insurance Board, or any other entity providing a plan of health insurance or health benefits in this state.

F. If child support services are being provided under the state child support plan as provided under Section 237 of Title 56 of the Oklahoma Statutes, the Child Support Enforcement Division shall notify the parent's employer to enroll the child in health care coverage available under the employer's plan by sending the employer a National Medical Support Notice issued pursuant to Section 466(a)(19) of the Social Security Act, and Section 609(a)(5)(C) of the Employee Retirement Income Security Act of 1974, as soon as the National Medical Support Notice is promulgated by the United States Department of Health and Human Services. The insurer, upon receipt from the employer of Part B of the National Medical Support Notice to Plan Administrator, shall comply with Part B of the National Medical Support Notice. The insurer may be fined up to Two Hundred Dollars (\$200.00) per month per child for each failure to comply with the requirements of the National Medical Support Notice. Fines collected shall be remitted to the Child Support Revenue Enhancement Fund created pursuant to Section 225 of Title 56 of the Oklahoma Statutes.

G. The Department of Human Services shall promulgate rules as necessary to implement the provisions of this section.

Added by Laws 1994, c. 27, § 1, emerg. eff. April 7, 1994. Amended by Laws 1998, c. 323, § 6, eff. Oct. 1, 1998; Laws 2001, c. 407, § 3, eff. July 1, 2001; Laws 2002, c. 22, § 12, emerg. eff. March 8, 2002; Laws 2003, c. 19, § 1, eff. Nov. 1, 2003; Laws 2004, c. 393, § 2, emerg. eff. June 3, 2004.

NOTE: Laws 2001, c. 63, § 1 repealed by Laws 2002, c. 22, § 34, emerg. eff. March 8, 2002

§36-6059. Adopted children - Coverage.

A. All individual and group health insurance policies providing coverage on an expense incurred, fixed, or capitated basis, and all individual and group insurance policies, certificates, service or indemnity type contracts issued by insurance companies, health maintenance organizations, nonprofit corporations, charitable and benevolent corporations established for the purposes of operating a nonprofit hospital service or indemnity plan and/or a nonprofit medical or indemnity, fixed, or capitated plan, and all self-insurers which provide coverage for a family member of the insured or subscriber shall, as to such family member's coverage, also provide that the health insurance benefits applicable for any natural child of the insured or subscriber shall be payable with respect to any adopted child of the insured or subscriber from the date of placement of the child in the custody of the insured or subscriber, provided the insurer is notified within thirty-one (31) days in writing. Coverage shall include the necessary care and treatment of medical conditions existing prior to the date of placement of the child in the custody of the insured or subscriber. Nothing in this section shall be construed to require coverage of costs incurred for such medical conditions prior to the date of placement of the child in the custody of the insured or subscriber.

B. Subject to the terms and conditions of the policy, contract or agreement, coverage shall also include the actual and documented medical costs associated with the birth of an adopted child who is eighteen (18) months of age or younger. If requested, the insured shall provide copies of medical bills and records associated with the birth of the adopted child and proof that the insured paid or is responsible for payment of the medical bills associated with the birth and that the cost of the birth was not covered by another health care plan including Medicaid. Any reference to the name of the natural parents of the adopted child shall be deleted from the records so provided. The coverage required by this subsection shall be subject to the same annual deductibles and coinsurance as may be deemed appropriate and as are consistent with those established for other covered benefits. The coverage shall also be subject to the terms of the insurers contract, if any, with hospitals and physicians.

C. As used in this section, "placement" means the assumption by the insured or subscriber of the physical custody of the adopted child and the financial responsibility for the support and care of the adopted child.

D. For purposes of this section, a child who is in the custody of the insured, pursuant to an interlocutory decree issued under Section 7505-6.1 of Title 10 of the Oklahoma Statutes vesting temporary care of the child in the insured, is an adopted child during the pendency of the adoption proceeding, regardless of whether a final decree of adoption is ultimately issued.

Added by Laws 1986, c. 39, § 1, eff. Nov. 1, 1986. Amended by Laws 1993, c. 154, § 1, eff. Sept. 1, 1993; Laws 1997, c. 41, § 1, eff. Nov. 1, 1997; Laws 1998, c. 415, § 42, emerg. eff. June 11, 1998; Laws 2006, c. 264, § 64, eff. July 1, 2006.

§36-6060. Mammography screening and diagnostic examination.

A. For the purposes of this section:

1. "Breast magnetic resonance imaging" means a diagnostic tool used to produce detailed pictures of the structure of the breast;
2. "Breast ultrasound" means a noninvasive, diagnostic imaging technique that uses high-frequency sound waves to produce detailed images of the breast;
3. "Diagnostic examination for breast cancer" means a medically necessary and clinically appropriate examination, as defined by current guidelines and as determined by a clinician who is evaluating the individual for breast cancer, to evaluate the abnormality in the breast that is:
 - a. seen or suspected from a screening examination for breast cancer,
 - b. detected by another means of examination, or
 - c. suspected based on the medical history or family medical history of the individual.

This examination may include, but is not limited to, a diagnostic mammogram, breast magnetic resonance imaging, or a breast ultrasound;

4. "Diagnostic mammography" means a diagnostic tool that:
 - a. uses X-ray, and
 - b. is designed to evaluate abnormality in a breast;
5. "Health benefit plan" means any plan or arrangement as defined in subsection C of Section 6060.4 of this title;
6. "Low-dose mammography" means:
 - a. the X-ray examination of the breast using equipment specifically dedicated for such purpose, with an average radiation exposure delivery of less than one rad mid-breast and with two views for each breast,
 - b. digital mammography, or
 - c. breast tomosynthesis;
7. "Breast tomosynthesis" means a radiologic mammography procedure involving the acquisition of projection images over a stationary breast to produce cross-sectional digital three-dimensional images of the breast from which breast cancer screening diagnoses may be made; and
8. "Screening mammography" means a radiologic procedure provided to a woman, who has no signs or symptoms of breast cancer, for the purpose of early detection of breast cancer, including breast tomosynthesis.

B. All health benefit plans shall include the coverage specified by this section for a low-dose mammography screening for the presence of occult breast cancer and a diagnostic examination for breast cancer. Such coverage shall not:

1. Be subject to the policy deductible, co-payments and co-insurance limits of the plan; or

2. Require that a female undergo a mammography screening at a specified time as a condition of payment.

C. 1. Any female thirty-five (35) through thirty-nine (39) years of age shall be entitled pursuant to the provisions of this section to coverage for a low-dose mammography screening once every five (5) years.

2. Any female forty (40) years of age or older shall be entitled pursuant to the provisions of this section to coverage for an annual low-dose mammography screening.

D. If application of this act would result in health savings account ineligibility under Section 223 of the federal Internal Revenue Code, as amended, the provisions of this section shall only apply to health savings accounts with qualified high deductible health plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible. Provided, however, the provisions of this section shall apply to items of services that are preventive care pursuant to Section 223(c)(2)(c) of the federal Internal Revenue Code, as amended, regardless of whether the minimum deductible has been satisfied.

Added by Laws 1988, c. 118, § 9, eff. Nov. 1, 1988. Amended by Laws 1989, c. 287, § 1, eff. Nov. 1, 1989; Laws 1993, c. 165, § 1, eff. Sept. 1, 1993; Laws 1994, c. 294, § 10, eff. Sept. 1, 1994; Laws 2001, c. 408, § 1, eff. July 1, 2001; Laws 2002, c. 78, § 1, emerg. eff. April 15, 2002; Laws 2008, c. 184, § 23, eff. July 1, 2008; Laws 2010, c. 222, § 29, eff. Nov. 1, 2010; Laws 2018, c. 158, § 1, eff. Nov. 1, 2018; Laws 2022, c. 294, § 1, eff. Nov. 1, 2022.

§36-6060.1. Bone density testing.

A. All individual and group health insurance policies providing coverage on an expense incurred basis, and all individual and group service or indemnity type contracts issued by a nonprofit corporation which provide coverage for a female forty-five (45) years of age or older in this state, except for policies that provide coverage for specified disease or other limited benefit coverage, shall include the coverage specified by this section for a bone density test to qualified individuals covered by the policy when such test is requested by a primary care or referral physician. The test shall be subject to the policy deductible, copayments and coinsurance limits of the plan; provided, however, no policy or contract shall be required to reimburse more than One Hundred Fifty Dollars (\$150.00) for any such test.

B. For purposes of this section:

1. "Qualified individual" means an individual:

a. with an estrogen hormone deficiency,

b. with:

(1) vertebral abnormalities,

(2) primary hyperparathyroidism, or

(3) a history of fragility bone fractures,

c. who is receiving long-term glucocorticoid, or

d. who is currently under treatment for osteoporosis; and

2. "Bone density test" means a medically accepted measurement of bone mass used to detect low bone mass and to determine a qualified individual's risk for osteoporosis.

Added by Laws 1996, c. 102, § 1, eff. Nov. 1, 1996.

§36-6060.2. Treatment of diabetes - Equipment, supplies and services.

A. 1. Every health benefit plan issued or renewed on or after November 1, 1996, shall, subject to the terms of the policy contract or agreement, include coverage for the following equipment, supplies and related services for the treatment of Type I, Type II, and gestational diabetes, when medically necessary and when recommended or prescribed by a physician or other licensed health care provider legally authorized to prescribe under the laws of this state:

a. blood glucose monitors,

b. blood glucose monitors to the legally blind,

c. test strips for glucose monitors,

d. visual reading and urine testing strips,

e. insulin,

f. injection aids,

g. cartridges for the legally blind,

h. syringes,

i. insulin pumps and appurtenances thereto,

j. insulin infusion devices,

k. oral agents for controlling blood sugar, and

l. podiatric appliances for prevention of complications associated with diabetes.

2. The State Board of Health shall develop and annually update, by rule, a list of additional diabetes equipment, related supplies and health care provider services that are medically necessary for the treatment of diabetes, for which coverage shall also be included, subject to the terms of the policy, contract, or agreement, if the equipment and supplies have been approved by the federal Food and Drug Administration (FDA). Additional FDA-approved diabetes equipment and related supplies, and health care provider services shall be determined in consultation with a national diabetes association affiliated with this state, and at least three

(3) medical directors of health benefit plans, to be selected by the State Department of Health.

3. All policies specified in this section shall also include coverage for:

- a. podiatric health care provider services as are deemed medically necessary to prevent complications from diabetes, and
- b. diabetes self-management training. As used in this subparagraph, "diabetes self-management training" means instruction in an inpatient or outpatient setting which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications. Diabetes self-management training shall comply with standards developed by the State Board of Health in consultation with a national diabetes association affiliated with this state and at least three medical directors of health benefit plans selected by the State Department of Health. Coverage for diabetes self-management training, including medical nutrition therapy relating to diet, caloric intake, and diabetes management, but excluding programs the only purpose of which are weight reduction, shall be limited to the following:
 - (1) visits medically necessary upon the diagnosis of diabetes,
 - (2) a physician diagnosis which represents a significant change in the symptoms or condition of the patient making medically necessary changes in the self-management of the patient, and
 - (3) visits when reeducation or refresher training is medically necessary;

provided, however, payment for the coverage required for diabetes self-management training pursuant to the provisions of this section shall be required only upon certification by the health care provider providing the training that the patient has successfully completed diabetes self-management training.

4. Diabetes self-management training shall be supervised by a licensed physician or other licensed health care provider legally authorized to prescribe under the laws of this state. Diabetes self-management training may be provided by the physician or other appropriately registered, certified, or licensed health care professional as part of an office visit for diabetes diagnosis or treatment. Training provided by appropriately registered, certified, or licensed health care professionals may be provided in group settings where practicable.

5. Coverage for diabetes self-management training and training related to medical nutrition therapy, when provided by a registered, certified, or licensed health care professional, shall also include home visits when medically necessary and shall include instruction in medical nutrition therapy only by a licensed registered dietician or licensed certified nutritionist when authorized by the supervising physician of the patient when medically necessary.

6. Coverage may be subject to the same annual deductibles or coinsurance as may be deemed appropriate and as are consistent with those established for other covered benefits within a given policy.

7. Any health benefit plan, as defined pursuant to Section 6060.4 of this title, that provides coverage for insulin pursuant to this section shall cap the total amount that a covered person is required to pay for insulin at an amount not to exceed Thirty Dollars (\$30.00) per thirty-day supply or Ninety Dollars (\$90.00) per ninety-day supply of insulin for each covered insulin prescription, regardless of the amount or type of insulin needed to fill the prescription or prescriptions of the covered person.

a. Nothing in this paragraph shall prevent a health benefit plan from reducing the cost-sharing of a covered person to an amount less than Thirty Dollars (\$30.00) per thirty-day supply or Ninety Dollars (\$90.00) per ninety-day supply.

b. The Insurance Commissioner shall ensure all health benefit plans comply with the requirements of this paragraph.

c. The Commissioner may promulgate rules as necessary to implement and administer the requirements of this paragraph and to align with federal requirements.

B. 1. Health benefit plans shall not reduce or eliminate coverage due to the requirements of this section.

2. Enforcement of the provisions of this act shall be performed by the Insurance Department and the State Department of Health.

C. As used in this section, "health benefit plan" means any plan or arrangement as defined in subsection C of Section 6060.4 of this title.

Added by Laws 1996, c. 125, § 1, eff. Nov. 1, 1996. Amended by Laws 2010, c. 222, § 30, eff. Nov. 1, 2010; Laws 2021, c. 61, § 1, eff. Nov. 1, 2021; Laws 2022, c. 199, § 1, eff. Nov. 1, 2022.

§36-6060.3. Maternity benefits - Postpartum care.

A. Every health benefit plan issued, amended, renewed or delivered in this state on or after July 1, 1996, that provides maternity benefits shall provide for coverage of:

1. A minimum of forty-eight (48) hours of inpatient care at a hospital, or a birthing center licensed as a hospital, following a

vaginal delivery, for the mother and newborn infant after childbirth, except as otherwise provided in this section;

2. A minimum of ninety-six (96) hours of inpatient care at a hospital following a delivery by caesarean section for the mother and newborn infant after childbirth, except as otherwise provided in this section; and

3. a. Postpartum home care following a vaginal delivery if childbirth occurs at home or in a birthing center that is not licensed as a hospital but that is accredited as a freestanding birth center by the Commission for the Accreditation of Birth Centers. The coverage shall provide for one home visit within forty-eight (48) hours of childbirth by a licensed health care provider whose scope of practice includes providing postpartum care. Visits shall include, at a minimum:
- (1) physical assessment of the mother and the newborn infant,
 - (2) parent education, to include, but not be limited to:
 - (a) the recommended childhood immunization schedule,
 - (b) the importance of childhood immunizations, and
 - (c) resources for obtaining childhood immunizations,
 - (3) training or assistance with breast or bottle feeding, and
 - (4) the performance of any medically necessary and appropriate clinical tests.

b. At the discretion of the mother, visits may occur at the facility of the plan or the provider.

B. Inpatient care shall include, at a minimum:

1. Physical assessment of the mother and the newborn infant;
2. Parent education, to include, but not be limited to:
 - a. the recommended childhood immunization schedule,
 - b. the importance of childhood immunizations, and
 - c. resources for obtaining childhood immunizations;
3. Training or assistance with breast or bottle feeding; and
4. The performance of any medically necessary and appropriate clinical tests.

C. A plan may limit coverage to a shorter length of hospital inpatient stay for services related to maternity and newborn infant care provided that:

1. In the sole medical discretion or judgment of the attending physician licensed by the State Board of Medical Licensure and Supervision or the State Board of Osteopathic Examiners or the certified nurse midwife licensed by the Oklahoma Board of Nursing

providing care to the mother and to the newborn infant, it is determined prior to discharge that an earlier discharge of the mother and newborn infant is appropriate and meets medical criteria contained in the most current treatment standards of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon:

- a. evaluation of the antepartum, intrapartum and postpartum course of the mother and newborn infant,
- b. the gestational age, birth weight and clinical condition of the newborn infant,
- c. the demonstrated ability of the mother to care for the newborn infant post-discharge, and
- d. the availability of post-discharge follow-up to verify the condition of the newborn infant in the first forty-eight (48) hours after delivery.

A plan shall adopt these guidelines by July 1, 1996; and

2. The plan covers one home visit, within forty-eight (48) hours of discharge, by a licensed health care provider whose scope of practice includes providing postpartum care. The visits shall include, at a minimum:

- a. physical assessment of the mother and the newborn infant,
- b. parent education, to include, but not be limited to:
 - (1) the recommended childhood immunization schedule,
 - (2) the importance of childhood immunizations, and
 - (3) resources for obtaining childhood immunizations,
- c. training or assistance with breast or bottle feeding, and
- d. the performance of any medically necessary and clinical tests.

At the mother's discretion, visits may occur at the facility of the plan or the provider.

D. The plan shall include, but is not limited to, notice of the coverage required by this section in the evidence of coverage of the plan, and shall provide additional written notice of the coverage to the insured or an enrollee during the course of the prenatal care of the insured or enrollee.

E. In the event the coverage required by this section is provided under a contract that is subject to a capitated or global rate, the plan shall be required to provide supplementary reimbursement to providers for any additional services required by that coverage if it is not included in the capitation or global rate.

F. No health benefit plan subject to the provisions of this section shall terminate the services of, reduce capitation payments for, refuse payment for services, or otherwise discipline a licensed

health care provider who orders care consistent with the provisions of this section.

G. As used in this section:

1. "Birthing center" has the same meaning as provided by Section 1-701 of Title 63 of the Oklahoma Statutes; and
2. "Health benefit plan" means any plan or arrangement as defined in subsection C of Section 6060.4 of this title.

H. The Insurance Commissioner shall promulgate any rules necessary to implement the provisions of this section.

Added by Laws 1996, c. 164, § 1, emerg. eff. May 14, 1996. Amended by Laws 1997, c. 149, § 1, eff. Nov. 1, 1997; Laws 2003, c. 464, § 5, eff. July 1, 2003; Laws 2010, c. 222, § 31, eff. Nov. 1, 2010; Laws 2024, c. 132, § 1, eff. Nov. 1, 2024.

§36-6060.3a. Annual obstetrical/gynecological examinations.

A. Any health benefit plan, including the State and Education Employees Group Health Insurance plan, that is offered, issued or renewed in this state on or after January 1, 2005, that provides medical and surgical benefits shall provide coverage for routine annual obstetrical/gynecological examinations.

B. The benefit required to be provided by this section shall in no way diminish or limit diagnostic benefits otherwise allowable under a health benefit plan.

C. Nothing in this section shall be construed as requiring such routine annual examination to be performed by an obstetrician, gynecologist, or obstetrician/gynecologist.

D. As used in this section, "health benefit plan" means any plan or arrangement as defined in subsection C of Section 6060.4 of this title, except that the term "health benefit plan" does not include policies or certificates issued to individuals or groups with fewer than fifty employees.

E. The provisions of this section shall not apply to policies or certificates issued to individuals or groups with fewer than fifty employees.

Added by Laws 2004, c. 397, § 1, eff. Nov. 1, 2004. Amended by Laws 2010, c. 222, § 32, eff. Nov. 1, 2010.

§36-6060.4. Child immunization coverage.

A. A health benefit plan delivered, issued for delivery or renewed in this state on or after January 1, 1998, that provides benefits for the dependents of an insured individual shall provide coverage for each child of the insured, from birth through the date the child is eighteen (18) years of age for:

1. Immunization against:
 - a. diphtheria,
 - b. hepatitis B,
 - c. measles,

- d. mumps,
- e. pertussis,
- f. polio,
- g. rubella,
- h. tetanus,
- i. varicella,
- j. haemophilus influenzae type B, and
- k. hepatitis A; and

2. Any other immunization subsequently required for children by the State Board of Health.

B. Benefits required pursuant to subsection A of this section shall not be subject to a deductible, co-payment, or coinsurance requirement.

C. 1. For purposes of this section, "health benefit plan" means group hospital coverage, individual and group medical insurance coverage, a not-for-profit hospital or medical service or indemnity plan, a prepaid health plan, a health maintenance organization plan, a preferred provider organization plan, the State and Education Employees Group Health Insurance Plan, and coverage provided by a Multiple Employer Welfare Arrangement or employee self-insured plan as permitted under Employee Retirement Income Security Act of 1974.

2. The term "health benefit plan" shall not include:

- a. a plan that provides coverage:
 - (1) only for a specified disease or diseases or under an individual limited benefit policy,
 - (2) only for accidental death or dismemberment,
 - (3) only for dental or vision care,
 - (4) a hospital confinement indemnity policy,
 - (5) disability income insurance or a combination of accident-only and disability income insurance, or
 - (6) as a supplement to liability insurance,
- b. a Medicare supplemental policy as defined by Section 1882(g)(1) of the Social Security Act (42 U.S.C., Section 1395ss),
- c. workers' compensation insurance coverage,
- d. medical payment insurance issued as part of a motor vehicle insurance policy,
- e. a long-term care policy, including a nursing home fixed indemnity policy, unless a determination is made that the policy provides benefit coverage so comprehensive that the policy meets the definition of a health benefit plan, or
- f. short-term health insurance issued on a nonrenewable basis with a duration of six (6) months or less.

Added by Laws 1997, c. 75, § 1, eff. Nov. 1, 1997. Amended by Laws 2000, c. 61, § 1, eff. Nov. 1, 2000; Laws 2003, c. 464, § 6, eff.

July 1, 2003; Laws 2006, c. 264, § 65, eff. July 1, 2006; Laws 2010, c. 222, § 33, eff. Nov. 1, 2010; Laws 2016, c. 73, § 7, eff. Nov. 1, 2016; Laws 2022, c. 199, § 2, eff. Nov. 1, 2022; Laws 2024, c. 195, § 10, eff. Nov. 1, 2024.

§36-6060.4a. Claims in conjunction with arrest or pretrial detention.

A. No health benefit plan, including, but not limited to, the State and Education Employees Group Health Insurance Plan, that is offered, issued or renewed in the state on or after January 1, 2009, shall exclude otherwise allowable claims which occur in conjunction with the arrest or pretrial detention of the policyholder prior to adjudication of guilt and sentencing to incarceration of the policyholder. The reimbursement rate for out-of-network claims for these services shall be set at the current Medicare rate.

B. As used in this section, "health benefit plan" means any plan or arrangement as defined in subsection C of Section 6060.4 of this title.

Added by Laws 2008, c. 351, § 1, eff. Nov. 1, 2008. Amended by Laws 2010, c. 222, § 34, eff. Nov. 1, 2010.

§36-6060.4b. Standard serological tests for syphilis.

A. As used in this section:

1. "Health benefit plan" has the same meaning as provided by Section 6060.4 of Title 36 of the Oklahoma Statutes; and

2. "Medically necessary" means services or supplies provided by a health care provider that are:

- a. provided for the diagnosis of syphilis,
- b. necessary for and appropriate to the diagnosis of syphilis,
- c. within the generally accepted standards of medical care in the community, and
- d. not solely for the convenience of the insured, the insured's family, or the provider.

B. A health benefit plan shall cover the cost of medically necessary standard serological tests for syphilis required under Section 1-515 of Title 63 of the Oklahoma Statutes.

Added by Laws 2023, c. 116, § 1, eff. Nov. 1, 2023.

§36-6060.5. Oklahoma Breast Cancer Patient Protection Act.

A. This section shall be known and may be cited as the "Oklahoma Breast Cancer Patient Protection Act".

B. Any health benefit plan that is offered, issued or renewed in this state on or after January 1, 1998, that provides medical and surgical benefits with respect to the treatment of breast cancer and other breast conditions shall ensure that coverage is provided for not less than forty-eight (48) hours of inpatient care following a

mastectomy and not less than twenty-four (24) hours of inpatient care following a lymph node dissection for the treatment of breast cancer.

C. Nothing in this section shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate.

D. Any plan subject to subsection B of this section shall also provide coverage for reconstructive breast surgery performed as a result of a partial or total mastectomy. Because breasts are a paired organ, any such reconstructive breast surgery shall include coverage for all stages of reconstructive breast surgery performed on a nondiseased breast to establish symmetry with a diseased breast when reconstructive surgery on the diseased breast is performed, provided that the reconstructive surgery and any adjustments made to the nondiseased breast must occur within twenty-four (24) months of reconstruction of the diseased breast.

E. In implementing the requirements of this section, a health benefit plan may not modify the terms and conditions of coverage based on the determination by an enrollee to request less than the minimum coverage required pursuant to subsections B and D of this section.

F. A health benefit plan shall provide notice to each insured or enrollee under the plan regarding the coverage required by this section in the evidence of coverage of the plan, and shall provide additional written notice of the coverage to the insured or enrollee as follows:

1. In the next mailing made by the plan to the employee;
 2. As part of any yearly informational packet sent to the enrollee; or
 3. Not later than December 1, 1997;
- whichever is earlier.

G. As used in this act, "health benefit plan" means any plan or arrangement as defined in subsection C of Section 6060.4 of this title.

H. The Insurance Commissioner shall promulgate any rules necessary to implement the provisions of this section.

Added by Laws 1997, c. 135, § 1, eff. Nov. 1, 1997. Amended by Laws 2003, c. 464, § 7, eff. July 1, 2003; Laws 2010, c. 222, § 35, eff. Nov. 1, 2010.

§36-6060.5a. Biomarker testing.

A. As used in this section:

1. "Biomarker" means a biological molecule found in blood, other body fluids, or tissues that is a sign of a normal or abnormal process, or of a condition or disease. A biomarker may be used to see how well the body responds to a treatment for a disease or

condition or for other purposes. Biomarkers shall include but are not limited to gene mutation or protein expression;

2. "Biomarker testing" means the analysis of a patient's tissue, blood, or other biospecimen for the presence of a biomarker. Biomarker testing shall include but not be limited to single-analyte tests, multiplex panel tests, gene or protein expression, and whole exome, whole genome, and whole transcriptome sequencing;

3. "Clinical utility" means the test result provides information that is used in the formulation of a treatment or monitoring strategy that informs a patient's outcome and impacts the clinical decision. The most appropriate test may include both information that is actionable and some information that cannot be immediately used in the formulation of a clinical decision;

4. "Consensus statement" means a statement that:

- a. is developed by an independent, multidisciplinary panel of experts that use a transparent methodology and reporting structure that includes a conflict of interest policy,
- b. is based on the best available evidence for the purpose of optimizing clinical care outcomes, and
- c. is aimed at specific clinical circumstances;

5. "Health benefit plan" means a plan as defined pursuant to Section 6060.4 of Title 36 of the Oklahoma Statutes; and

6. "Nationally recognized clinical practice guidelines" means evidence-based clinical practice guidelines that:

- a. are developed by independent organizations or medical professional societies using a transparent methodology and reporting structure and a conflict of interest policy, and
- b. establish standards of care that are informed by a systemic review of evidence and an assessment of the benefits and costs of alternative care options that includes recommendations intended to optimize patient care.

B. Any health benefit plan, including the Oklahoma Employees Insurance Plan, that is offered, issued, or renewed in this state on or after the effective date of this act shall provide coverage for biomarker testing. A contract provided with a health benefit plan under this section shall include biomarker testing for the purpose of diagnosis, treatment, appropriate management, or ongoing monitoring of an insured's disease or condition to guide treatment decisions when the biomarker test provides clinical utility as demonstrated by medical and scientific evidence including, but not limited to:

1. Labeled indications for tests that are approved or cleared by the United States Food and Drug Administration;

2. Indicated tests for a drug that is approved by the United States Food and Drug Administration;

3. Warnings and precautions on United States Food and Drug Administration-approved drug labels;

4. Centers for Medicare and Medicaid Services national coverage determinations or Medicare administrative contractor local coverage determinations; or

5. Nationally recognized clinical practice guidelines and consensus statements.

C. A health benefit plan shall ensure that coverage is provided in a manner that limits disruptions in care, including the need for multiple biopsies and biospecimen samples.

D. An insured and a prescribing practitioner shall have access to a clear, readily available, and convenient process to request an exception to a coverage policy of a health benefit plan under this subsection. The process shall be readily accessible on the plan's website. This subsection shall not be construed to require a separate process if the health benefit plan's existing process complies with this subsection.

Added by Laws 2023, c. 331, § 1, eff. Jan. 1, 2024.

§36-6060.6. Dental procedures for certain minor and severely disabled persons.

A. Any health benefit plan that is offered, issued or renewed in this state on or after January 1, 1999, that provides hospitalization benefits shall provide coverage for anesthesia expenses including anesthesia practitioner expenses for the administration of the anesthesia, and hospital and ambulatory surgical center expenses associated with any medically necessary dental procedure when provided to a covered person who is:

1. Severely disabled; or

2. a. A minor eight (8) years of age or under, and who has a medical or emotional condition which requires hospitalization or general anesthesia for dental care, or

b. A minor four (4) years of age or under, who in the judgment of the practitioner treating the child, is not of sufficient emotional development to undergo a medically necessary dental procedure without the use of anesthesia.

B. A health benefit plan may require prior authorization for either inpatient or outpatient hospitalization for dental care in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

C. Coverage provided for in subsection A of this section shall be subject to the same annual deductibles, copayments or coinsurance

limits as established for all other covered benefits under the health benefit plan.

D. As used in this section, "health benefit plan" means any plan or arrangement as defined in subsection C of Section 6060.4 of this title.

Added by Laws 1998, c. 66, § 1, eff. Nov. 1, 1998. Amended by Laws 1999, c. 98, § 1, eff. July 1, 1999; Laws 2010, c. 222, § 36, eff. Nov. 1, 2010.

§36-6060.7. Audiological services and hearing aids for children.

A. 1. Any health benefit plan that is offered, issued, or renewed on or after the effective date of this act shall provide coverage for audiological services and hearing aids for children up to eighteen (18) years of age.

2. Such coverage:

- a. shall only apply to hearing aids that are prescribed, filled and dispensed by a licensed audiologist, and
- b. may limit the hearing aid benefit payable for each hearing-impaired ear to every forty-eight (48) months; provided, however, coverage may provide for up to four additional ear molds per year for children up to two (2) years of age.

B. Nothing in this section shall be construed to extend the practice or privileges of any health care provider beyond that provided in the laws governing the practice and privileges of the provider.

C. As used in this section, "health benefit plan" means any plan or arrangement as defined in subsection C of Section 6060.4 of this title.

Added by Laws 1999, c. 136, § 1, eff. Nov. 1, 1999. Amended by Laws 2002, c. 30, § 1, eff. Nov. 1, 2002; Laws 2010, c. 222, § 37, eff. Nov. 1, 2010.

§36-6060.8. Prostate cancer screening coverage.

A. Any health benefit plan that is offered, issued or renewed in this state on or after January 1, 2000, that provides coverage to men forty (40) years of age or older in this state shall offer coverage for annual screening for the early detection of prostate cancer in men over the age of fifty (50) years and in men over the age of forty (40) years who are in high-risk categories. The coverage shall not be subject to policy deductibles. The coverage shall not exceed the actual cost of the prostate cancer screening up to a maximum of Sixty-five Dollars (\$65.00) per screening.

B. The benefit required to be provided by subsection A of this section shall in no way diminish or limit diagnostic benefits otherwise allowable under a health benefit plan.

C. The prostate cancer screening coverage shall be offered as follows:

1. The screening shall be performed by a qualified medical professional including, but not limited to, a urologist, internist, general practitioner, doctor of osteopathy, nurse practitioner, or physician assistant;

2. The screening shall consist, at a minimum, of the following tests:

a. a prostate-specific antigen blood test, and

b. a digital rectal examination;

3. At least one screening per year shall be covered for any man fifty (50) years of age or older; and

4. At least one screening per year shall be covered for any man from forty (40) to fifty (50) years of age who is at increased risk of developing prostate cancer as determined by a physician.

D. As used in this section, "health benefit plan" means any plan or arrangement as defined in subsection C of Section 6060.4 of this title.

Added by Laws 1999, c. 137, § 1, eff. Nov. 1, 1999. Amended by Laws 2003, c. 464, § 8, eff. July 1, 2003; Laws 2010, c. 222, § 38, eff. Nov. 1, 2010.

NOTE: Editorially renumbered from Title 36, § 6060.7 to avoid a duplication in numbering.

§36-6060.8a. Colorectal cancer coverage.

A. Any health benefit plan, including the State and Education Employees Group Health Insurance Plan, that is offered, issued or renewed in this state on or after January 1, 2002, which provides medical and surgical benefits, shall offer coverage for colorectal cancer examinations and laboratory tests for cancer for any nonsymptomatic covered individual, in accordance with standard, accepted published medical practice guidelines for colorectal cancer screening, who is:

1. At least fifty (50) years of age; or

2. Less than fifty (50) years of age and at high risk for colorectal cancer according to the standard, accepted published medical practice guidelines.

B. The coverage provided for by this section shall be subject to the same annual deductibles, co-payments or coinsurance limits as established for other covered benefits under the health plan.

C. To minimize costs for nonsymptomatic screening, third-party reimbursement may be at the existing Medicaid rate which shall be payment in full.

D. As used in this section, "health benefit plan" means any plan or arrangement as defined in subsection C of Section 6060.4 of this title; provided, however, the provisions of this section shall not apply to policies or certificates issued to individuals or to

groups with fifty (50) or fewer employees, or to plans offered under the state Medicaid program.

Added by Laws 2001, c. 409, § 1, eff. Nov. 1, 2001. Amended by Laws 2010, c. 222, § 39, eff. Nov. 1, 2010.

§36-6060.8b. Coverage for fertility preservation services – Iatrogenic infertility.

A. As used in this section:

1. "Health benefit plan" means a health benefit plan as defined pursuant to Section 6060.4 of Title 36 of the Oklahoma Statutes;

2. "Iatrogenic infertility" means an impairment of fertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment with a potential side effect of impaired fertility as established by the American Society of Clinical Oncology or the American Society for Reproductive Medicine;

3. "Religious employer" means an employer that is a church, convention or association of churches, or an elementary or secondary school that is controlled, operated, or principally supported by a church or a convention or association of churches as defined pursuant to Section 3121(w) (3) (A) of the Internal Revenue Code and that qualifies as a tax-exempt organization under Section 501(c) (3) of the Internal Revenue Code;

4. "Reproductive age" means the age range in which an individual is deemed fertile as established by the American Society of Clinical Oncology and/or the American Society for Reproductive Medicine; and

5. "Standard fertility preservation services" means oocyte and sperm preservation procedures, including ovarian tissue, sperm, and oocyte cryopreservation, that are consistent with established medical practices or professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine; provided, however, standard fertility preservation services shall not include storage.

B. 1. Any health benefit plan, including the Oklahoma Employees Insurance Plan, that is offered, issued, or renewed on and after the effective date of this act shall provide coverage for standard fertility preservation services, only for individuals diagnosed with cancer and who are within reproductive age, when a medically necessary treatment may directly or indirectly cause iatrogenic infertility.

2. A health benefit plan shall not require preauthorization for coverage of standard fertility preservation services; however, a health benefit plan may contain provisions for maximum benefits and may subject the covered service to the same deductible, copayment, coinsurance, and reasonable limitations and exclusions to the extent that these applications are not inconsistent with the provisions of this section.

C. 1. A religious employer may submit a written request for exemption to a carrier of a health benefit plan, and such carrier shall grant the exemption if the coverage required by this section conflicts with the religious employer's bona fide religious beliefs and practices. A religious employer that obtains an exemption pursuant to this subsection shall provide prospective enrollees of its health benefit plan with written notice of the exemption.

2. Nothing in this subsection shall prohibit an enrollee of a health benefit plan provided by his or her religious employer from purchasing, at his or her own expense, a supplemental insurance policy that covers standard fertility preservation services.

Added by Laws 2024, c. 349, § 2, eff. Jan. 1, 2025.

§36-6060.9. Coverage for wigs or other scalp prostheses.

A. Any health benefit plan, including the State and Education Employees Group Health Insurance Plan, that is offered, issued, or renewed in this state on or after January 1, 2001, that provides medical and surgical benefits with respect to the treatment of cancer and other conditions treated by chemotherapy or radiation therapy shall provide coverage for wigs or other scalp prostheses necessary for the comfort and dignity of the covered person.

B. The coverage provided for by this section shall be subject to the same annual deductibles, copayments, or coinsurance limits as established for all other covered benefits under the health benefit plan not to exceed One Hundred Fifty Dollars (\$150.00) annually.

C. A health benefit plan shall provide notice to each insured or enrollee under the plan regarding the coverage required by this section in the evidence of coverage of the plan and shall provide additional written notice of the coverage to the insured or enrollee as follows:

1. In the next mailing made by the plan to the insured or enrolled employee;

2. As part of any yearly informational packet sent to the enrollee; or

3. Not later than December 1, 2000;
whichever is earlier.

D. As used in this act, "health benefit plan" means any plan or arrangement as defined in subsection C of Section 6060.4 of this title. However, this section shall not apply to policies or certificates issued to individuals or groups with fifty (50) or fewer employees or plans offered under the State Medicaid Program.

E. The Insurance Commissioner shall promulgate any rules necessary to implement the provisions of this section.

Added by Laws 2000, c. 171, § 4, eff. July 1, 2000. Amended by Laws 2010, c. 222, § 40, eff. Nov. 1, 2010.

§36-6060.9a. Anti-cancer medication coverage.

A. 1. Any health benefit plan that provides coverage and benefits for cancer treatment shall provide coverage of prescribed orally administered anticancer medications on a basis no less favorable than intravenously administered or injected cancer medications.

2. Coverage of orally administered anticancer medication shall not be subject to any prior authorization, dollar limit, copayment, deductible, or other out-of-pocket expense that does not apply to intravenously administered or injected cancer medication, regardless of formulation or benefit category determination by the company administering the health benefit plan.

3. A health benefit plan shall not reclassify or increase any type of cost-sharing to the covered person for anticancer medications in order to achieve compliance with this section. Any change in health insurance coverage that otherwise increases an out-of-pocket expense to anticancer medications shall also be applied to the majority of comparable medical or pharmaceutical benefits covered by the health benefit plan.

4. A health benefit plan that limits the total amount paid by a covered person through all cost-sharing requirements to no more than One Hundred Dollars (\$100.00) per filled prescription for any orally administered anticancer medication shall be considered in compliance with this section. For purposes of this paragraph, "cost-sharing requirements" shall include copayments, coinsurance, deductibles, and any other amounts paid by the covered person for that prescription.

B. As used in this section:

1. "Anticancer medications" means medications used to kill or slow the growth of cancer cells;

2. "Covered person" means a policyholder, subscriber, enrollee, or other individual enrolled in or insured by a health benefit plan for health insurance coverage; and

3. "Health benefit plan" means any plan or arrangement as defined in subsection C of Section 6060.4 of Title 36 of the Oklahoma Statutes.

Added by Laws 2013, c. 115, § 1, eff. Nov. 1, 2013.

§36-6060.9b. Cancer therapy coverage - Standard for proton radiation therapy.

A. A health benefit plan, as defined in subsection C of Section 6060.4 of Title 36 of the Oklahoma Statutes, that provides coverage for cancer therapy shall be prohibited from holding proton radiation therapy to a higher standard of clinical evidence for medical policy benefit coverage decisions than the health plan requires for coverage of any other radiation therapy treatment.

B. Nothing in this section shall be construed to mandate the coverage of proton radiation therapy by a health benefit plan.

Added by Laws 2015, c. 74, § 1, eff. Nov. 1, 2015.

§36-6060.9c. Anti-abuse-formulated opioids - Study of effectiveness
The College of Pharmacy at Southwestern Oklahoma State University shall analyze the effectiveness of the anti-abuse properties of anti-abuse-formulated opioids. In addition, the College of Pharmacy shall analyze the discrepancies between insurance coverage for the anti-abuse-formulated prescription opioids and coverage for prescription opioids without abuse-deterrent properties. Such information shall be submitted in a report to the President Pro Tempore of the Senate and the Speaker of the House of Representatives on or before December 31, 2016.
Added by Laws 2016, c. 381, § 1, eff. Nov. 1, 2016.

§36-6060.9d. Prescription eyedrop refills.

A. Any health benefit plan issued or renewed on or after November 1, 2017, that provides coverage for prescription eyedrops shall not deny coverage for a refill of a prescription if:

1. For a thirty-day supply, the amount of time has passed after which a patient should have used seventy percent (70%) of the dosage units of the drug according to a practitioner's instructions, or twenty-one (21) days from:

- a. the original date the prescription was distributed to the insured, or
- b. the date the most recent refill was distributed to the insured;

2. The prescribing practitioner indicates on the original prescription that additional quantities are needed;

3. The refill requested by the insured does not exceed the number of additional quantities needed; and

4. The prescription eyedrops prescribed by the practitioner are a covered benefit under the policy or contract to the insured.

B. As used in this section, "health benefit plan" means any plan or arrangement as defined in subsection C of Section 6060.4 of Title 36 of the Oklahoma Statutes.

Added by Laws 2017, c. 15, § 1, eff. Nov. 1, 2017.

§36-6060.10. Definitions.

As used in this act:

1. "Base period" means the period of coverage pursuant to the issuance or renewal of a health benefit plan that is required to provide benefits pursuant to the provisions of Section 6060.11 of this title;

2. "Health benefit plan" means any plan or arrangement as defined in subsection C of Section 6060.4 of this title;

3. "Insurer" means any entity providing an accident and health insurance policy in this state including, but not limited to, a

licensed insurance company, a not-for-profit hospital service and medical indemnity corporation, a fraternal benefit society, a multiple employer welfare arrangement or any other entity subject to regulation by the Insurance Commissioner;

4. "Mental health and substance use disorder" means any condition or disorder involving a mental health condition or substance use disorder listed under any of the diagnostic categories in the mental disorders section of the most recent edition of the International Classification of Disease or in the mental disorders section of the most recent version of the Diagnostic and Statistical Manual of Mental Disorders; and

5. "Mental health and substance use disorder benefits" means benefits covering items or services for mental health conditions or substance use disorders, as defined under the terms of the health benefit plan and in accordance with applicable federal and state law. Any condition defined by the plan as a mental health condition or not a mental health condition shall be consistent with the definition of that condition included in generally recognized independent standards of current medical practice, including but not limited to the most recent version of the Diagnostic and Statistical Manual of Mental Disorders or the most recent edition of the International Classification of Disease.

Added by Laws 1999, c. 153, § 1, eff. Jan. 1, 2000. Amended by Laws 2010, c. 222, § 41, eff. Nov. 1, 2010; Laws 2020, c. 75, § 1, eff. Nov. 1, 2020.

§36-6060.10A. Health benefit plan.

A. 1. No health benefit plan shall deny coverage, refuse to issue or renew, cancel or otherwise terminate, restrict or exclude any person from any health benefit plan issued or renewed on or after November 1, 2010, on the basis of the applicant's or insured's status as a victim of domestic abuse as defined in Section 60.1 of Title 22 of the Oklahoma Statutes.

2. No health benefit plan shall deny a claim on the basis of the insured's status as a victim of domestic violence.

3. Domestic abuse shall not be considered to be a preexisting condition.

B. As used in this section, "health benefit plan" means individual or group coverage, a not-for-profit hospital or medical service or indemnity plan, a prepaid health plan, a health maintenance organization plan, a preferred provider organization plan, the State and Education Employees Group Health Insurance Plan, any program funded under Title XIX of the Social Security Act or such other publicly funded program, and coverage provided by a Multiple Employer Welfare Arrangement (MEWA) or employee self-insured plan except as exempt under federal ERISA provisions.

C. In order to comply with the provisions of this section, the acts constituting the domestic abuse shall be reported to a law enforcement agency setting forth the relevant facts.
Added by Laws 2010, c. 385, § 1, eff. Nov. 1, 2010.

§36-6060.11. Benefits required.

A. Subject to the limitations set forth in this section and Sections 6060.12 and 6060.13 of this title, any health benefit plan that is offered, issued, or renewed in this state on or after January 1, 2000, shall provide benefits for treatment of mental health and substance use disorders.

B. 1. Benefits for mental health and substance use disorders shall be equal to benefits for treatment of and shall be subject to the same preauthorization and utilization review mechanisms and other terms and conditions as all other physical diseases and disorders including, but not limited to:

- a. coverage of inpatient hospital services for either twenty-six (26) days or the limit for other covered illnesses, whichever is greater,
- b. coverage of outpatient services,
- c. coverage of medication,
- d. maximum lifetime benefits,
- e. copayments,
- f. coverage of home health visits,
- g. individual and family deductibles, and
- h. coinsurance.

2. Treatment limitations applicable to mental health or substance use disorder benefits shall be no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan. There shall be no separate treatment limitations that are applicable only with respect to mental health or substance abuse disorder benefits.

C. A health benefit plan shall not impose a nonquantitative treatment limitation with respect to mental health and substance use disorders in any classification of benefits unless, under the terms of the health benefit plan as written and in operation, any processes, strategies, evidentiary standards or other factors used in applying the nonquantitative treatment limitation to mental health disorders in the classification are comparable to and applied no more stringently than to medical and surgical benefits in the same classification.

D. All health benefit plans must meet the requirements of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and federal guidance or regulations issued under these acts including 45 CFR 146.136, 45 CFR 147.160, 45 CFR 156.115(a)(3), 42 U.S.C. 300gg-26(a), 29 U.S.C. 1185a(a), and 26 U.S.C. 9812.

E. Beginning on or after January 1, 2000, each insurer that offers, issues or renews any individual or group health benefit plan providing mental health or substance use disorder benefits shall submit an annual report to the Insurance Commissioner on or before April 1 of each year that contains the following:

1. A description of the process used to develop or select the medical necessity criteria for mental health and substance use disorder benefits and the process used to develop or select the medical necessity criteria for medical and surgical benefits;

2. Identification of all nonquantitative treatment limitations applied to both mental health and substance use disorder benefits and medical and surgical benefits within each classification of benefits; and

3. The results of an analysis that demonstrates that for the medical necessity criteria described in paragraph 1 of this subsection and for each nonquantitative treatment limitation identified in paragraph 2 of this subsection, as written and in operation, the processes, strategies, evidentiary standards or other factors used in applying the medical necessity criteria and each nonquantitative treatment limitation to mental health and substance use disorder benefits within each classification of benefits are comparable to and are applied no more stringently than to medical and surgical benefits in the same classification of benefits. At a minimum, the results of the analysis shall:

- a. identify and clearly define the factors and terms used to determine that a nonquantitative treatment limitation will apply to a benefit,
- b. identify and clearly define the specific evidentiary standards used to define the factors and any other evidence relied upon in designing each nonquantitative treatment limitation,
- c. provide the detailed, written, and reasoned comparative analyses including the results of the analyses performed to determine that the processes and strategies used to design each nonquantitative treatment limitation, as written, and the as written processes and strategies used to apply the nonquantitative treatment limitation to mental health and substance use disorder benefits are comparable to and applied no more stringently than the processes and strategies used to design each nonquantitative treatment limitation, as written, and the as written processes and strategies used to apply the nonquantitative treatment limitation to medical and surgical benefits,
- d. provide the detailed, written, and reasoned comparative analyses including the results of the

- analyses performed to determine that the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for mental health and substance use disorder benefits are comparable to and applied no more stringently than the processes or strategies used to apply each nonquantitative treatment limitation for medical and surgical benefits in the same classification of benefits, and
- e. disclose the specific findings and conclusions reached by the insurer that the results of the analyses required by this subsection indicate whether the insurer is in compliance with this section and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and its implementing and related regulations including 45 CFR 146.136, 45 CFR 147.160, 45 CFR 156.115(a)(3), 42 U.S.C. 300gg-26(a), 29 U.S.C. 1185a(a), and 26 U.S.C. 9812.

F. The findings and conclusions shall include sufficient detail to fully explain such findings including methodologies for the analyses, detailed descriptions of each treatment limitation for mental health and substance use disorder benefits compared to each treatment limitation for medical and surgical benefits, and detailed descriptions of all criteria involved for approving mental health and substance use disorder benefits as compared to the criteria involved for approving medical and surgical benefits.

G. The Commissioner shall implement and enforce any applicable provisions of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and federal guidance or regulations issued under these acts including 45 CFR 146.136, 45 CFR 147.136, 45 CFR 147.160, 45 CFR 156.115(a)(3), 42 U.S.C. 300gg-26(a), 29 U.S.C. 1185a(a), and 26 U.S.C. 9812.

H. The Commissioner shall issue guidance and standardized reporting templates to ensure compliance with the provisions of this section. Guidance shall include examples of non-quantitative treatment limitations as identified by the Centers for Medicare and Medicaid Services, the Department of Labor, and the Employee Benefits Security Administration.

I. No later than December 31, 2021, and by December 31 of each year thereafter, the Commissioner shall make available to the public the reports submitted by insurers, as required in subsection E of this section, during the most recent annual cycle.

1. The Commissioner shall identify insurers that have failed in whole or in part to comply with the full extent of reporting required in this section and shall make a reasonable attempt to obtain missing reports or information by June 1 of the following year.

2. The reports submitted by insurers and the identification by the Commissioner of noncompliant insurers shall be made available to the public by posting on the Internet website of the Insurance Department. Any information that is confidential or a trade secret shall be redacted prior to the public posting.

J. The Commissioner may promulgate rules pursuant to the provisions of this section and any provisions of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, that relate to the business of insurance. Added by Laws 1999, c. 153, § 2, eff. Jan. 1, 2000. Amended by Laws 2010, c. 222, § 42, eff. Nov. 1, 2010; Laws 2020, c. 75, § 2, eff. Nov. 1, 2020; Laws 2021, c. 478, § 28, emerg. eff. May 12, 2021; Laws 2022, c. 312, § 1, eff. Nov. 1, 2022.

§36-6060.11a. Procedure to assist plan members in accessing out-of-network behavioral health care providers.

A. For the purposes of this act:

1. "Health benefit plan" means a health benefit plan as defined pursuant to Section 6060.4 of Title 36 of the Oklahoma Statutes;

2. "Health care provider" or "provider" means a health care provider as defined pursuant to Section 6571 of Title 36 of the Oklahoma Statutes; and

3. "Timely manner" means:

- a. for a request for a routine appointment, a provider's referral for services, the start of a new treatment or medication, or other maintenance services, as determined by the Insurance Department, thirty (30) days from the date that the insured requests the appointment, service, or care,
- b. for residential care or hospitalization, seven (7) days from the date that the insured first attempts to receive care, and
- c. for urgent, emergency, or crisis care, twenty-four (24) hours from the date and time that the insured first attempts to receive care.

B. A health benefit plan must establish a documented procedure to assist a plan member in accessing an out-of-network behavioral health care provider when no in-network behavioral health care provider is available within a timely manner.

C. If the beneficiary of a health benefit plan is unable to obtain covered behavioral health services from an in-network provider in a timely manner as defined in subsection A of this section, including medically appropriate telehealth services, such plan shall ensure coverage of the behavioral health services from an out-of-network provider by arranging a network exception with a negotiated rate from an out-of-network provider. Such an agreement between the health benefit plan and the out-of-network provider

shall hold the beneficiary harmless for any amount greater than the in-network cost-sharing amount, including copayment, coinsurance, and deductible, that the beneficiary would have paid had the same services been rendered by an in-network provider. The negotiated rate in the network exception, in addition to the beneficiary's in-network cost-sharing amount, shall be accepted as payment in full for the provided behavioral health services. In no instance shall the beneficiary pay more than the in-network cost-sharing amount for such services.

D. A plan shall not be held responsible if behavioral health services are available within a timely manner, as defined in this section, but the beneficiary chooses to schedule services outside the timely access standard.

E. A health benefit plan that makes a payment to an out-of-network provider pursuant to this section shall document the details of the payment to be made available to the Department upon request not later than twenty (20) days from the date requested.

F. The Department may promulgate rules to ensure compliance with and effectuate the provisions of this section.

G. The Insurance Department shall have the authority to investigate when an insurer has failed to ensure coverage as required by this section. After the conclusion of an investigation, the Department may use all available tools to levy fees or fines for noncompliance.

Added by Laws 2023, c. 284, § 1, eff. Nov. 1, 2023.

§36-6060.11b. Reimbursement for benefits delivered through behavioral health integration and psychiatric collaborative care models.

A. For the purposes of this section:

1. "Behavioral health integration" means an approach to delivering mental health care that improves the ability for primary care providers to include mental and behavioral health screening, treatment, and specialty care into their practice pursuant to Current Procedural Terminology billing code 99484, as established by the American Medical Association;

2. "Health benefit plan" means a plan as defined pursuant to Section 6060.4 of Title 36 of the Oklahoma Statutes;

3. "Mental health and substance abuse disorder benefits" means benefits for the treatment of any condition or disorder that involves a mental health condition or substance abuse disorder, including, but not limited to, those that fall under any of the diagnostic categories listed in the mental disorders section of the most recent edition of the International Classification of Diseases or in the mental disorders section of the most recent version of the Diagnostic and Statistical Manual of Mental Disorders;

4. "Oklahoma Medicaid Program" means the state program administered by the Oklahoma Health Care Authority pursuant to Section 1002 of Title 56 of the Oklahoma Statutes; and

5. "Psychiatric collaborative care model" means the evidence-based, integrated behavioral health service delivery method described pursuant to 81 C.F.R. 80230. The model shall include, but not be limited to, the following Current Procedural Terminology billing codes, as established by the American Medical Association:

- a. 99492,
- b. 99493, and
- c. 99494.

B. 1. Any health benefit plan that is offered, issued, or renewed in this state and that provides mental health or substance abuse disorder benefits shall provide reimbursement for such benefits that are delivered through the behavioral health integration and psychiatric collaborative care models.

2. The Oklahoma Medicaid Program shall provide reimbursement for such benefits that are delivered through the behavioral health integration and psychiatric collaborative care models.

3. Plans offered, issued, or renewed in this state that provide benefits under this subsection may deny reimbursement of any Current Procedural Terminology code pursuant to paragraph 3 of subsection A of this section due to medical necessity; provided, such medical necessity determinations shall be in compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and its implementing and related regulations, and in accordance with the utilization review requirements pursuant to Section 6551 et seq. of Title 36 of the Oklahoma Statutes and the review and denial of mental health and substance abuse disorder treatments and services in Section 1250.5 et seq. of Title 36 of the Oklahoma Statutes.

Added by Laws 2023, c. 374, § 1, eff. Nov. 1, 2023.

NOTE: Editorially renumbered from § 6060.11a of this title to avoid a duplication in numbering.

§36-6060.12. Exempted plans - Calculation of increase in premium cost.

1. A health benefit plan that, at the end of its base period, experiences a greater than two percent (2%) increase in premium costs pursuant to providing benefits for treatment of mental health and substance use disorders shall be exempt from the provisions of Section 6060.11 of this title.

2. To calculate base-period-premium costs, the health benefit plan shall subtract from premium costs incurred during the base period, both the premium costs incurred during the period immediately preceding the base period and any premium cost increases

attributable to factors unrelated to benefits for treatment of mental health and substance use disorders.

3. a. To claim the exemption provided for in paragraph 1 of this section a health benefit plan shall provide to the Insurance Commissioner a written request signed by an actuary stating the reasons and actuarial assumptions upon which the request is based.
- b. The Commissioner shall verify the information provided and shall approve or disapprove the request within thirty (30) days of receipt.
- c. If, upon investigation, the Commissioner finds that any statement of fact in the request is found to be knowingly false, the health benefit plan may be subject to suspension or loss of license or any other penalty as determined by the Commissioner with regard to health maintenance organizations.

Added by Laws 1999, c. 153, § 3, eff. Jan. 1, 2000. Amended by Laws 2020, c. 75, § 3, eff. Nov. 1, 2020; Laws 2021, c. 478, § 29, emerg. eff. May 12, 2021.

§36-6060.13. Incremental impact on premium costs - Analysis and report by Commissioner.

A. The Insurance Commissioner shall analyze any direct incremental impact on premium costs pursuant to the requirements of Section 6060.11 of this title. The Commissioner shall submit a report of all preliminary data and findings to the Governor, the President Pro Tempore of the Senate and the Speaker of the House of Representatives by May 1, 2000, with subsequent updates submitted by November 1, 2000; May 1, 2001; November 1, 2001; May 1, 2002, and November 1, 2002.

B. 1. The Commissioner shall submit a final report to the Governor, the President Pro Tempore of the Senate and the Speaker of the House of Representatives by December 1, 2002, which shall include, but not be limited to, the collection and analysis of data provided by health benefit plans including, but not limited to:

- a. a determination of the average premium increase directly attributable to providing benefits for treatment of mental health and substance use disorders pursuant to the provisions of Section 6060.11 of this title by health benefit plans in this state incurred during the first year of implementation of Section 6060.10 et seq. of this title, and any additional premium increases incurred during the second and third year of implementation,
- b. information on the number of claims filed and the total amount expended on those claims for benefits for

treatment of mental health and substance use disorders,

- c. information on the utilization of services listed in subsection C of Section 6060.11 of this title, and
- d. actuarial assumptions used in determining premium costs for providing the required benefits.

2. The final report shall also include, to the extent possible, an analysis of any other direct or indirect benefit of requiring benefits for treatment of mental health and substance use disorders.

C. 1. All health benefit plans shall provide the data required by this subsection in such form and at such time as the Commissioner shall prescribe.

2. The Commissioner shall compile and report the data provided by the health benefit plans in such a way as to keep individual plan information confidential, unless the plan gives explicit permission to release such identifiable information.

D. If the report required by subsection A of this section shows that the cumulative average premium increase incurred during the first three (3) years of implementation of Section 6060.10 et seq. of this title that is directly attributable to the provision of benefits for treatment of mental health and substance use disorders is greater than six percent (6%), the requirements of Section 2 of this act shall terminate May 1, 2003, and any agreement, contract or policy issued after May 1, 2003, shall not be required to provide benefits for treatment of mental health and substance use disorders. Added by Laws 1999, c. 153, § 4, eff. Jan. 1, 2000. Amended by Laws 2020, c. 75, § 4, eff. Nov. 1, 2020.

§36-6060.14. Short title.

This act shall be known and may be cited as the "Health Savings Account Act".

Added by Laws 2005, c. 306, § 1, eff. Nov. 1, 2005.

§36-6060.15. Definitions.

As used in this act:

1. "Deductible" means the total deductible for an eligible individual and all the dependents of that eligible individual for a calendar year;

2. "Dependent" means the spouse or child of the eligible individual as defined in Section 152 of the Internal Revenue Code;

3. "Eligible individual" means the individual taxpayer, including employees of an employer who contributes to health savings accounts on the employees' behalf, who:

- a. must be covered by a "high deductible health plan" individually or with dependent,

- b. may not be covered under any health plan that is not a high deductible health plan, except for:

- (1) coverage for accidents,
- (2) workers' compensation insurance,
- (3) insurance for a specified disease or illness,
- (4) insurance paying a fixed amount per day per hospitalization, and
- (5) tort liabilities, and

c. establishes the health savings account, or on whose behalf the health savings account is established;

4. "Health savings account" or "account" means a trust or custodian established in this state pursuant to a health savings account program exclusively to pay the qualified medical expenses of an eligible individual or their dependents, but only if the written governing instrument creating the account meets the following requirements:

- a. except in the case of a rollover contribution, no contribution will be accepted:
 - (1) unless it is in cash, or
 - (2) to the extent the contribution, when added to the previous contributions to the account for the calendar year, exceeds the maximum contribution amount pursuant to Section 223 of the Internal Revenue Code,
- b. the trustee or custodian is a bank, a credit union, an insurance company, or another person approved by the United States Secretary of Health and Human Services,
- c. no part of the trust assets will be invested in life insurance contracts,
- d. the assets of the account will not be commingled with other property except as allowed for under Individual Retirement Accounts, and
- e. eligible individual's interest in the account is nonforfeitable;

5. "Health savings account program" or "program" means a program that includes all of the following:

- a. the purchase by an eligible individual or by an employer of a high deductible health plan, and
- b. the contribution into a health savings account by an eligible individual or on behalf of an employee or by their employer. The total annual contribution may not exceed the maximum contribution amount pursuant to Section 223 of the Internal Revenue Code;

6. "High deductible health plan" means a health coverage policy, certificate, or contract that provides for payments for covered benefits that exceed the higher deductible;

7. "Qualified medical expense" means an expense paid by the taxpayer for medical care described in paragraph d of Section 213 of

the Internal Revenue Code, but only to the extent such amounts are not compensated for by insurance or otherwise; and

8. "High deductible" means:

- a. in the case of self-only coverage, an annual deductible which is not less than One Thousand Dollars (\$1,000.00) and the sum of the annual deductible and other annual out-of-pocket expenses required to be paid under the plan for covered benefits does not exceed Five Thousand Dollars (\$5,000.00), or
- b. in the case of family coverage, an annual deductible of not less than Two Thousand Dollars (\$2,000.00) and the sum of the annual deductible and other annual out-of-pocket expenses required to be paid under the plan for covered benefits does not exceed Ten Thousand Dollars (\$10,000.00).

A plan shall not fail to be treated as a high deductible plan by reason of failing to have a deductible for preventive care or, in the case of network plans, for having out-of-pocket expenses which exceed these limits on an annual deductible for services provided outside the network.

Added by Laws 2005, c. 306, § 2, eff. Nov. 1, 2005. Amended by Laws 2007, c. 269, § 1, emerg. eff. June 4, 2007.

§36-6060.16. Eligibility - Contributions - Exemptions.

A. The provisions of this act shall also apply to taxpayers who are not receiving preferred federal tax treatment for a health savings account pursuant to Section 223 of the Internal Revenue Code.

B. For taxable years beginning after 2005, a resident of Oklahoma or an employer shall be allowed to deposit contributions to a health savings account. The amount of deposit for each year shall not exceed the maximum contribution amount pursuant to Section 223 of the Internal Revenue Code.

C. Except as provided in Section 6060.18 of this title, the following are exempt from taxation under the Oklahoma Income Tax Act:

1. Principal contributed to and interest earned on a health savings account; and
2. Money reimbursed to an eligible individual or an employee for qualified medical expenses.

Added by Laws 2005, c. 306, § 3, eff. Nov. 1, 2005. Amended by Laws 2007, c. 269, § 2, emerg. eff. June 4, 2007.

§36-6060.17. Allowable expenditures.

The trustee or custodian shall utilize the funds held in a health savings account solely for the following purposes:

1. To pay the qualified medical expenses of the eligible individual or their dependents; or
 2. To purchase a health coverage policy certificate, or contract, if the eligible individual:
 - a. is receiving unemployment compensation,
 - b. is exercising continuation privileges under federal law, or
 - c. is purchasing a long-term care insurance contract; or
 3. To pay for health insurance other than a Medicare supplemental policy for those who are Medicare eligible.
- Added by Laws 2005, c. 306, § 4, eff. Nov. 1, 2005. Amended by Laws 2007, c. 269, § 3, emerg. eff. June 4, 2007.

§36-6060.18. Withdrawals - Taxation - Transfer of interest.

A. Notwithstanding paragraphs C, D, E, and F of this section, an eligible individual may withdraw money from their health savings account for any purpose other than a purpose described in Section 6060.17 of this title.

B. If the eligible individual withdraws money for any purpose other than a purpose described in Section 6060.17 of this title, at any other time, all of the following shall apply:

1. The amount of the withdrawal is income for the purposes of the Oklahoma Income Tax Act in the tax year of the withdrawal; and
2. The tax imposed on the withdrawal which is includable in income shall be increased by ten percent (10%) of the amount which is so includable.

C. The amount of disbursement of any assets of a health savings account pursuant to a filing for protection under Section 101 of Title 11 of the United States Code by an eligible individual or person for whose benefit the account was established is not considered a withdrawal for purposes of this section. The amount of a disbursement is not subject to taxation under the Oklahoma Income Tax Act and subsection B of this section does not apply.

D. The transfer of an eligible individual's interest in a health savings account to an eligible individual's spouse or former spouse under a divorce or separation instrument shall not be considered a taxable transfer made by such eligible individual, notwithstanding any other provision of this title, and the interest shall, after the transfer, be treated as a health savings account with respect to which the spouse is the eligible individual.

E. Upon the death of the eligible individual, the trustee or custodian shall distribute the principal and accumulated interest of the health savings account to the estate of the deceased.

F. If an employee becomes employed with a different employer that participates in a health savings account program, the employee may transfer their health savings account to that new employer's

trustee or custodian, or to an individually purchased account program.

Added by Laws 2005, c. 306, § 5, eff. Nov. 1, 2005. Amended by Laws 2007, c. 269, § 4, emerg. eff. June 4, 2007.

§36-6060.20. Equal health coverage for autistic minors.

A. All individual and group health insurance policies that provide medical and surgical benefits shall provide the same coverage and benefits to any individual under the age of eighteen (18) years who has been diagnosed with an autistic disorder as it would provide coverage and benefits to an individual under the age of eighteen (18) years who has not been diagnosed with an autistic disorder.

B. As used in this section, "autistic disorder" means a neurological disorder that is marked by severe impairment in social interaction, communication, and imaginative play, with onset during the first three (3) years of life and is included in a group of disorders known as autism spectrum disorders.

Added by Laws 2010, c. 166, § 2, eff. Nov. 1, 2010. Amended by Laws 2016, c. 230, § 3, eff. Nov. 1, 2016.

§36-6060.21. Screening, diagnosis and treatment of autism spectrum disorder.

A. For all plans issued or renewed on or after November 1, 2016, a health benefit plan and the Oklahoma Employees Health Insurance Plan shall provide coverage for the screening, diagnosis and treatment of autism spectrum disorder in individuals. No insurer shall terminate coverage, or refuse to deliver, execute, issue, amend, adjust or renew coverage to an individual solely because the individual is diagnosed with or has received treatment for an autism spectrum disorder.

B. Coverage under this section shall be subject to the provisions set forth in Section 6060.11 of this title; provided, however, that coverage shall not be subject to any limits on the number of visits an individual may make for treatment of autism spectrum disorder.

C. Coverage under this section shall not be subject to dollar limits, deductibles or coinsurance provisions that are less favorable to an insured than the dollar limits, deductibles or coinsurance provisions that apply to substantially all medical and surgical benefits under the health benefit plan.

D. This section shall not be construed as limiting benefits that are otherwise available to an individual under a health benefit plan.

E. Coverage for applied behavior analysis shall include the services provided or supervised by a board-certified behavior

analyst, a board-certified assistant behavior analyst or a licensed doctoral-level psychologist.

F. Except for inpatient services, if an insured is receiving treatment for an autism spectrum disorder, an insurer shall have the right to review the treatment plan annually, unless the insurer and the insured's treating physician or psychologist agree that a more frequent review is necessary. Any such agreement regarding the right to review a treatment plan more frequently shall apply only to a particular insured being treated for an autism spectrum disorder and shall not apply to all individuals being treated for autism spectrum disorder by a physician or psychologist. The cost of obtaining any review or treatment plan shall be borne by the insurer.

G. This section shall not be construed as affecting any obligation to provide services to an individual under an individualized family service plan, an individualized education program or an individualized service plan.

H. As used in this section:

1. "Applied behavior analysis" means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior;

2. "Autism spectrum disorder" means any of the pervasive developmental disorders or autism spectrum disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the edition that was in effect at the time of diagnosis;

3. "Behavioral health treatment" means counseling and treatment programs including applied behavior analysis, that are:

- a. necessary to develop, maintain or restore, to the maximum extent practicable, the functioning of an individual, and
- b. provided or supervised by a board-certified behavior analyst, a board-certified assistant behavior analyst or by a licensed doctoral-level psychologist so long as the services performed are commensurate with the psychologist's university training and experience;

4. "Diagnosis of autism spectrum disorder" means medically necessary assessment, evaluations or tests to diagnose whether an individual has an autism spectrum disorder;

5. "Health benefit plan" means any plan or arrangement as defined in subsection C of Section 6060.4 of Title 36 of the Oklahoma Statutes;

6. "Oklahoma Employees Health Insurance Plan" means "Health Insurance Plan" as defined in Section 1303 of Title 74 of the Oklahoma Statutes;

7. "Pharmacy care" means medications prescribed by a licensed physician and any health-related services deemed medically necessary to determine the need or effectiveness of the medications;

8. "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices;

9. "Psychological care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices;

10. "Therapeutic care" means services provided by licensed or certified speech therapists, occupational therapists or physical therapists; and

11. "Treatment for autism spectrum disorder" means evidence-based care and related equipment prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a licensed physician or a licensed doctoral-level psychologist who determines the care to be medically necessary including, but not limited to:

- a. behavioral health treatment,
- b. pharmacy care,
- c. psychiatric care,
- d. psychological care, and
- e. therapeutic care.

Added by Laws 2016, c. 230, § 1, eff. Nov. 1, 2016. Amended by Laws 2019, c. 437, § 2, eff. Nov. 1, 2019; Laws 2022, c. 154, § 8, eff. Nov. 1, 2022.

§36-6060.22. Exemption for health benefit plans from autism spectrum disorder coverage.

A. 1. A health benefit plan that, at the end of its base period, experiences a greater than one percent (1%) increase in premium costs pursuant to providing applied behavior analysis for treatment of autism spectrum disorders shall be exempt from the provisions of this act.

2. To calculate base-period-premium costs, the health benefit plan shall subtract from premium costs incurred during the base period, both the premium costs incurred during the period immediately preceding the base period and any premium cost increases attributable to factors unrelated to benefits for treatment of autism spectrum disorders.

3. a. To claim the exemption provided for in subsection A of this section a health benefit plan shall provide to the Insurance Commissioner a written request signed by an actuary stating the reasons and actuarial assumptions upon which the request is based.

- b. The Commissioner shall verify the information provided and shall approve or disapprove the request within thirty (30) days of receipt.
- c. If, upon investigation, the Commissioner finds that any statement of fact in the request is found to be knowingly false, the health benefit plan may be subject to suspension or loss of license or any other penalty as determined by the Commissioner, or the State Commissioner of Health with regard to health maintenance organizations.

Added by Laws 2016, c. 230, § 4, eff. Nov. 1, 2016.

§36-6060.30. Living organ donor protection.

No insurer in this state shall refuse to insure, or refuse to continue to insure, or limit the amount, extent or kind of coverage available for life insurance, disability insurance or long-term care insurance to an individual, or charge an individual a different rate for the same coverage solely because of his or her status as a living organ donor. With respect to all other conditions, persons who are living organ donors shall be subject to the same standards of sound actuarial principles or actual or reasonably anticipated experience as are persons who are not organ donors.

Added by Laws 2019, c. 33, § 1, eff. Nov. 1, 2019.

§36-6060.40. Short title - Oklahoma Right to Shop Act.

This act shall be known and may be cited as the "Oklahoma Right to Shop Act".

Added by Laws 2022, c. 151, § 1.

§36-6060.41. Definitions.

As used in the Oklahoma Right to Shop Act:

1. "Allowed amount" means the contractually agreed-upon amount paid by a carrier to a health care entity participating in the network of the carrier;
2. "Comparable health care service" means any covered nonemergency health care service or bundle of services. The Insurance Commissioner may limit what is considered a comparable health care service if an insurance carrier can demonstrate allowed amount variation among network providers is less than Fifty Dollars (\$50.00);
3. "Health benefit plan" means any plan as defined in subsection C of Section 6060.4 of Title 36 of the Oklahoma Statutes;
4. "Insurance carrier" or "carrier" means an insurance company that issues policies of accident and health insurance and is licensed to sell insurance in this state;
5. "Shared savings incentive" means a voluntary and optional financial incentive that an insurance carrier may provide to an

enrollee for choosing certain health care services under a shared savings incentive program; and

6. "Shared savings incentive program" means a voluntary and optional incentive program established by an insurance carrier pursuant to this act.

Added by Laws 2022, c. 151, § 2.

§36-6060.42. Shared savings incentive program.

A. An insurance carrier may offer a shared savings incentive program to provide incentives to an enrollee when the enrollee obtains a comparable health care service that is covered by the carrier from providers that charge less than the average allowed amount paid by that carrier to network providers for that, comparable health care service.

B. Incentives may be calculated as a percentage of the difference in allowed amounts to the average, as a flat dollar amount, or by any other reasonable methodology approved by the Insurance Department. The carrier shall provide the incentive as a cash payment to the enrollee or credit toward the annual in-network deductible and out-of-pocket limit of the enrollee. Carriers may allow enrollees to select which method the enrollee prefers to receive the incentive.

C. An insurance carrier that offers a shared savings incentive program shall:

1. Establish the program as a component part of the policy or certificate of insurance provided by the carrier and notify the enrollees and the Insurance Department at least thirty (30) days before program termination;

2. File a description of the program on a form prescribed by the Insurance Commissioner. The Insurance Department shall review the filing and determine whether the program complies with the provisions of this section;

3. Notify an enrollee, annually or at the time of renewal, of the availability of the shared savings incentive program and the procedures to participate in the program;

4. Publish on the website of the insurance carrier, easily accessible to enrollees and applicants for insurance, a list of comparable health care services and health care providers and the shared savings incentive amount applicable for each service. A shared savings incentive shall not be less than twenty-five percent (25%) of the savings generated by the participation of the enrollee in any shared savings incentive program offered by the insurance carrier. The baseline for the savings calculation shall be the average in-network amount paid for that service in the most recent twelve-month period or any other methodology established by the insurance carrier and approved by the Insurance Department;

5. At least quarterly, credit, deposit or make a cash payment to an enrollee of the shared savings incentive amount pursuant to participation in the shared savings incentive program; and

6. Submit an annual report to the Insurance Department within ninety (90) days after the close of each health benefit plan year. At a minimum, the report shall include the following information:

- a. the number of enrollees who participated in the program during the health benefit plan year and the number of instances of participation,
- b. the total cost of services provided as a part of the program, and
- c. the total value of the shared savings incentive payments made to enrollees participating in the program and the values distributed as cash or credit toward the annual in-network deductible and out-of-pocket limit of an enrollee.

D. An enrollee shall not be required to participate in a shared savings incentive program.

Added by Laws 2022, c. 151, § 3.

§36-6060.43. Promulgation of rules.

The Insurance Department shall promulgate necessary rules for the implementation of the Oklahoma Right to Shop Act.

Added by Laws 2022, c. 151, § 4.

§36-6060.44. Cost-effectiveness analysis.

The Office of Management and Enterprise Services shall conduct an analysis no later than November 1, 2022, of the cost-effectiveness of implementing a shared savings incentive program, as defined in paragraph 6 of Section 2 of this act, for current enrollees of the Oklahoma Employees Insurance Plan created pursuant to the Oklahoma State Employees Benefit Act. If a program is found to be cost-effective, it shall be implemented as part of the next open enrollment. The Office shall communicate the rationale for its decision to the President Pro Tempore of the Senate, the Speaker of the House of Representatives, and the chairs of the relevant legislative committees in writing.

Added by Laws 2022, c. 151, § 5.

§36-6061. Separate accounts - Variable annuity and life insurance contracts - Regulations.

A. Any domestic life insurance company may establish one or more separate accounts, and may allocate to such separate account or accounts any amounts including without limitation proceeds applied under optional modes of settlement or under dividend options to provide for life insurance or annuities and benefits incidental

thereto, payable in fixed or in variable dollar amounts, or in both, subject to the following:

1. Except as hereinafter provided, the amounts allocated to each such account and accumulations thereon may be invested and reinvested without regard to any requirements or limitations prescribed by the laws of this state governing the investments of life insurance companies; provided, that to the extent that the company's reserve liability with regard to a. benefits guaranteed as to amounts and duration, and b. funds guaranteed as to principal amount or stated rate of interest is maintained in any separate account, a portion of the assets of such separate account at least equal to such reserve liability shall be, except as the Commissioner may otherwise approve, invested in accordance with the laws of this state governing the investments of life insurance companies. The investments in such separate account or accounts shall not be taken into account in applying the investment limitations applicable to other investments of the company.

2. With respect to seventy-five percent (75%) of the market value of the total assets in a separate account no company shall purchase or otherwise acquire the securities of any issuer, other than securities issued or guaranteed as to principal or interest by the United States, if immediately after such purchase or acquisition the market value of such investment, together with prior investments of such separate account in such security taken at market value, would exceed ten percent (10%) of the market value of the assets of said separate account; provided, however, that the Commissioner may waive such limitations if, in his opinion, such waiver will not render the operation of such separate account hazardous to the public or the policyholders in this state.

3. No separate account shall invest in the voting securities of a single issuer if such investment would result in the company owning an amount in excess of ten percent (10%) of the total issued and outstanding voting securities of such issuer; provided, that the foregoing shall not apply with respect to securities held in separate accounts, the voting rights in which are exercisable only in accordance with instructions from persons having interest in such accounts.

4. The limitations provided in subsections 2. and 3. above shall not apply to the investment with respect to a separate account in the securities of an investment company registered under the Investment Company Act of 1940, provided that the investments of such investment company comply in substance with subsections 2. and 3. hereof.

5. The income, if any, and gains and losses, realized or unrealized, from assets allocated to each account shall be credited to or charged against the account in accordance with the applicable

contract without regard to other income, gains or losses of the company.

6. Assets allocated to a separate account shall be valued at their market value on the date of valuation, or if there is no readily available market, then in accordance with the applicable contract or the rules or other written agreement applicable to such separate account; provided, the portion of the assets of such separate account at least equal to the company's reserve liability with regard to the guaranteed benefits and funds referred to in subsection 1. hereof, if any, shall be valued in accordance with the rules otherwise applicable to the company's assets. The reserve liability for variable contracts shall be determined in accordance with actuarial procedures that recognize the variable nature of the benefits provided and any mortality guarantees.

7. If, and to the extent, so provided under the applicable contracts, that portion of the assets of any such separate account equal to the reserves, and other contract liabilities with respect to such account, shall not be chargeable with liabilities arising out of any other business the company may conduct.

8. The life insurance company shall have the power and the company's charter shall be deemed amended to authorize such company to do all things necessary under any applicable state or federal law in order that variable contracts may be lawfully sold or offered for sale including, without limitation, a. with respect to any separate account registered with the Securities and Exchange Commission as a unit investment trust exercise voting rights in connection with any securities of a regulated investment company registered under the Investment Company Act of 1940 and held in such separate accounts in accordance with instructions from persons having interests in such accounts ratably as determined by the company, or b. with respect to any separate account registered with the Securities and Exchange Commission as a management investment company, establish for such account a committee, board, or other body, the members of which may or may not be otherwise affiliated with such company and may be elected to such membership by the vote of persons having interests in such account ratably as determined by the company. Such committee, board or other body may have the power, exercisable alone or in conjunction with others, to manage such separate account and the investment of its assets.

B. Any contract providing benefits payable in variable amounts delivered or issued for delivery in this state shall contain a statement of the essential features of the procedure to be followed by the company in determining the dollar amount of such variable benefits. Any such contract under which the benefits vary to reflect investment experience, including a group contract and any certificate issued thereunder shall state that such dollar amount

may decrease or increase and shall contain on its first page a statement that the benefits thereunder are on a variable basis.

C. No domestic life insurance company, and no other life insurance company admitted to transact business in this state, shall be authorized to deliver within this state any variable contract providing benefits in variable amounts until said company has satisfied the Insurance Commissioner that its condition or methods of operation in connection with the issuance of such contracts will not render its operation hazardous to the public or its policyholders in this state. In determining the qualification of a company requesting authority to deliver such contracts within this state, the Insurance Commissioner shall consider, among other things:

1. The history and financial condition of the company;
2. The character, responsibility and general fitness of the officers and directors of the company; and
3. In the case of a company other than a domestic company, whether the statutes and regulations of the jurisdiction of its incorporation, or state of entry in the case of an alien company, provide a degree of protection to policyholders and the public which is substantially equal to that provided by this section and the rules and regulations issued thereunder.

An authorized life insurance company, whether domestic, foreign or alien, which issues variable contracts and which is a subsidiary of (or affiliated through common management or ownership with) another life insurance company authorized to do business in this state may be deemed to have met the provisions of this subsection if either it or the parent or affiliated company meets the requirements hereof.

D. The Insurance Commissioner shall have the sole and exclusive authority to regulate the issuance and sale of such contracts and to issue such reasonable rules and regulations as may be necessary to carry out the purposes and provisions of this section; and such contracts, the companies which issue them and the agents or other persons who sell them shall not be subject to the Oklahoma Uniform Securities Act of 2004 nor to the jurisdiction of the Oklahoma Securities Commission thereunder.

Added by Laws 1967, c. 287, § 1, emerg. eff. May 8, 1967. Amended by Laws 1969, c. 94, § 1, emerg. eff. March 27, 1969; Laws 1973, c. 194, § 1, emerg. eff. May 16, 1973; Laws 2022, c. 77, § 5, eff. Nov. 1, 2022.

§36-6062. Application of insurance laws.

Except for Sections 4003, 4008, 4009, 4010, 4011, 4017, 4021, 4022, 4029, subsection 1 of 4103, 4106 and 4109, and except as otherwise provided in this act, all pertinent provisions of the insurance laws of this state shall apply to separate accounts and

contracts relating thereto, provided, that such individual contracts delivered in this state shall contain grace, reinstatement and nonforfeiture provisions appropriate to such contracts. Any group variable life insurance contract delivered in this state shall contain a grace provision appropriate to such contract. Laws 1967, c. 287, § 2, emerg. eff. May 8, 1967; Laws 1969, c. 94, § 2, emerg. eff. March 27, 1969; Laws 1973, c. 194, § 2, emerg. eff. May 16, 1973.

§36-6071. Payment of commissions to officers or directors of life insurance companies - Restrictions.

No life insurance company transacting business in this State shall pay, or contract to pay, directly or indirectly, to its president, vice president, secretary, treasurer, actuary, medical director or other physician charged with the duty of examining risks or applications for insurance or to any officer of the company other than a designated agency officer directly responsible for the production and maintenance of premium income, agent or solicitor, any commission or other compensation contingent upon the writing or procuring of any policy of insurance in such company, or procuring an application therefor by any person whomsoever, or contingent upon the payment of any renewal premium, or upon the assumption of any life insurance risk by such company. This section shall not prevent the payment or receipt of renewal or other deferred commissions to or by any person solely because such person has ceased to hold a license to act as an agent. Should any company violate any provision of this article, it shall be the duty of the Insurance Commissioner to revoke its certificate of authority to transact business in this State.

Laws 1967, c. 326, § 1, emerg. eff. May 16, 1967.

§36-6091. Settlement of claims as no admission of liability.

No settlement made under a motor vehicle liability insurance policy of a claim against any insured thereunder arising from any accident or other event insured against shall be construed as an admission of liability by the insured, or the insurer's recognition of such liability, with respect to any other claim arising from the same accident or event and no testimony with respect to such settlement shall be admissible in evidence with respect to any other such claim.

Laws 1968, c. 220, § 1, emerg. eff. April 23, 1968.

§36-6092. Limitations on subrogation and set-off under medical coverage.

No provision in an automobile liability policy or endorsement for such coverage effective in this state issued by an insurer on and after the effective date of this act which grants the insurer

the right of subrogation for payment of benefits under the expenses for the medical services coverage portion of the policy, to a named insured under the policy, or to any relative of the named insured who is a member of the named insured's household shall be valid and enforceable; provided, that such policy or endorsement may provide for said insurer's rights of subrogation and set-off upon such payments to any person who is not a named insured under the policy or a relative of the named insured who is a member of the named insured's household.

Added by Laws 1971, c. 127, § 1, emerg. eff. May 5, 1971.

§36-6101. Joinder of companies to issue supplemental coverage - Approval - Rules and regulations.

Individual insurance companies transacting business in Oklahoma and engaged in the sale and issuance of accident and health or hospitalization insurance may, and are hereby authorized to form an association for the apportionment among such companies of applicants for policies of insurance granting coverage supplemental in nature to the benefits granted by Medicare. Any such proposed plan of association shall be subject to the approval of the Insurance Commissioner, and all forms of policies, endorsements, and other forms shall be approved by the Insurance Commissioner prior to use or issuance in Oklahoma. The Insurance Commissioner may promulgate such reasonable rules and regulations as may be necessary or proper to carry out the provision of this act.

Laws 1969, c. 81, § 1, emerg. eff. March 18, 1969.

§36-6103. Repealed by Laws 1994, c. 294, § 25, eff. Sept. 1, 1994.

§36-6103.1. Purpose of act.

A. The purpose of Sections 11 through 21 of this act is to subject certain persons and insurers to the jurisdiction of:

1. The Insurance Commissioner, including proceedings before the Commissioner; and

2. The courts of this state in suits by or on behalf of this state and insureds or beneficiaries under insurance contracts.

B. The Legislature declares that it is a subject of concern that many residents of this state hold policies of insurance issued by persons and insurers not authorized to do insurance business in this state, thus presenting to such residents the often insuperable obstacle of asserting their legal rights under such policies in forums foreign to them under laws and rules of practice with which they are not familiar. The Legislature declares that it is also concerned with the protection of residents of this state against acts by persons and insurers not authorized to do an insurance business in this state by:

1. The maintenance of fair and honest insurance markets;

2. Protecting the premium tax revenues of this state;
3. Protecting authorized persons and insurers which are subject to strict regulation from unfair competition by unauthorized persons and insurers; and
4. Protecting against the evasion of the insurance regulatory laws of this state.

Added by Laws 1994, c. 294, § 11, eff. Sept. 1, 1994.

§36-6103.2. "Insurer", "venue" and "doing insurance business in this state" defined - Exceptions.

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. 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 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;
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.

Added by Laws 1994, c. 294, § 12, eff. Sept. 1, 1994. Amended by Laws 1997, c. 418, § 103, eff. Nov. 1, 1997; Laws 2009, c. 176, § 37, eff. Nov. 1, 2009.

§36-6103.3. Engaging in the business of insurance without statutory authorization - Remedies of Insurance Commissioner.

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 or any other business which is subject to the jurisdiction of the Insurance Commissioner.

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, or any other business for which authorization from the Insurance Commissioner is required, 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.

Added by Laws 1994, c. 294, § 13, eff. Sept. 1, 1994. Amended by Laws 1997, c. 418, § 104, eff. Nov. 1, 1997; Laws 2009, c. 176, § 38, eff. Nov. 1, 2009; Laws 2015, c. 298, § 13, eff. Nov. 1, 2015.

§36-6103.4. Hearing.

A. 1. If the Insurance Commissioner has reason to believe or it appears that a person or insurer has violated or is threatening to violate the provisions of Sections 6103.1 through 6103.11 of this title or a rule promulgated pursuant thereto, or that a 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 an unfair method of competition or an unfair or deceptive act or practice as defined in Section 1201 et seq. of this title or a rule promulgated pursuant thereto, the Commissioner may set a hearing and shall serve on that person or insurer allegations of fact and a notice of hearing, in conformance with the Administrative Procedures Act and the Oklahoma Insurance Code, and the applicable rules thereof.

2. The hearing must be held not earlier than the 5th day or later than the 30th day after the date of service of the statement and notice unless the parties, with prior written approval of the Commissioner, mutually agree to some other arrangements. Process may be served by registered mail, return receipt requested, to the person's last-known address.

3. The hearing shall be conducted in the manner provided for contested cases under the Administrative Procedures Act and the Oklahoma Insurance Code, and the applicable rules thereof.

B. 1. After the hearing, the Commissioner may issue an order against the person or insurer charged with a violation requiring that the person or insurer immediately cease and desist from the violation.

2. A person aggrieved by a final order or decision of the Insurance Commissioner pursuant to Sections 6103.1 through 6103.11 of this title may seek judicial review pursuant to Section 318 of Title 75 of the Oklahoma Statutes.

C. The Insurance Commissioner may promulgate reasonable rules necessary to carry out this section.

D. The Insurance Commissioner may proceed under Sections 6103.1 through 6103.11 of this title or under any other applicable law without regard to prior proceedings.

Added by Laws 1994, c. 294, § 14, eff. Sept. 1, 1994. Amended by Laws 1997, c. 418, § 105, eff. Nov. 1, 1997.

§36-6103.5. Emergency cease and desist orders - Grounds for issuance.

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.

Added by Laws 1994, c. 294, § 15, eff. Sept. 1, 1994. Amended by Laws 1997, c. 418, § 106, eff. Nov. 1, 1997; Laws 2009, c. 176, § 39, eff. Nov. 1, 2009.

§36-6103.6. Emergency cease and desist orders - Service - Hearing.

A. On issuance of an emergency cease and desist order under Section 6103.5 of this title, the Insurance Commissioner shall serve on the person affected by the order, by registered or certified mail, return receipt requested, to the person's last-known address, or by other lawful means, an order that contains a statement of the charges and require the person immediately to cease and desist from the acts, methods or practices stated.

B. 1. If a person affected by an emergency cease and desist order seeks to contest that order, the person may request a hearing before the Commissioner. The person affected must request the hearing not later than the 30th day after the date on which the person receives the order. A request to contest an order must be in writing and directed to the Commissioner and must state the grounds for the request to set aside or modify the order.

2. On receiving the request for a hearing, the Commissioner shall serve notice of the time and place of the hearing at which the person requesting the hearing shall have the opportunity to show cause why the order should not be affirmed. The hearing is to be held not later than the 10th day after the date the Commissioner receives the request for a hearing unless the parties mutually agree to a later hearing date.

3. Pending the hearing, an emergency cease and desist order continues in full force and effect unless the order is stayed by the Commissioner.

4. The hearing on the order shall be conducted according to the procedures for contested cases under the Administrative Procedures Act.

5. At the hearing, the Commissioner shall affirm, modify or set aside in whole or in part the emergency cease and desist order.

C. A person aggrieved by a final order and decision of the Commissioner pursuant to Sections 6103.1 through 6103.11 of this title may seek judicial review pursuant to Section 318 of Title 75 of the Oklahoma Statutes.

D. The Commissioner may recover reasonable attorney's fees if judicial action is necessary for enforcement of the order.

E. A cease and desist order is final thirty-one (31) days after the date it is received if the person affected by the order does not request a hearing as provided by subsection B of this section.

Added by Laws 1994, c. 294, § 16, eff. Sept. 1, 1994. Amended by Laws 1997, c. 418, § 107, eff. Nov. 1, 1997.

§36-6103.7. Cease and desist orders - Enforcement.

A. 1. If the Insurance Commissioner reasonably believes that a person has violated a cease and desist order issued under Sections 6103.1 through 6103.11 of this title, the Commissioner may:

- a. initiate individual proceedings under this section pursuant to the Administrative Procedures Act,
- b. initiate proceedings to revoke the certificate of authority of the person affected by a ruling or action issued under Sections 6103.1 through 6103.11 of this title, or
- c. pursue any other action the Commissioner deems appropriate under applicable law.

2. In determining whether a cease and desist order has been violated, the Commissioner shall consider the maintenance of procedures reasonably adopted to ensure compliance with the order. The hearing shall be conducted according to the procedure for contested cases under the Administrative Procedures Act.

B. After a hearing, if the Commissioner determines that a cease and desist order has been violated, the Commissioner may:

1. Impose a civil penalty of Twenty-five Thousand Dollars (\$25,000.00) for each act of violation;

2. Direct the person against whom the order was issued to make complete restitution, in the form and amount and within the period determined by the Commissioner, to all Oklahoma residents, Oklahoma insureds, and entities operating in Oklahoma damaged by the violation or failure to comply; or

3. Both impose the penalty and direct restitution.

C. A person aggrieved by a final order or decision of the Commissioner pursuant to Sections 6103.1 through 6103.11 of this title may seek judicial review pursuant to Section 318 of Title 75 of the Oklahoma Statutes. The Commissioner may recover reasonable attorney's fees if judicial action is necessary to enforce an order. Added by Laws 1994, c. 294, § 17, eff. Sept. 1, 1994. Amended by Laws 1997, c. 418, § 108, eff. Nov. 1, 1997.

§36-6103.8. Failure to pay penalty.

If a person fails to pay a penalty assessed under the provisions of Sections 6103.1 through 6103.11 of this title, the Insurance Commissioner may:

1. Institute in the district court of Oklahoma County a civil suit to recover the civil penalty; or
2. Pursuant to the Administrative Procedures Act, cancel or revoke any permit, license, certificate of authority, certificate of registration or other authorization issued pursuant to the Oklahoma Insurance Code.

Added by Laws 1994, c. 294, § 18, eff. Sept. 1, 1994. Amended by Laws 1997, c. 418, § 109, eff. Nov. 1, 1997.

§36-6103.9. Service of process.

A. 1. Service of process on a person as defined in Section 6103.3 of this title in a civil suit for injunctive relief under Section 6103.3 of this title or to recover a civil penalty under Section 6103.7 of this title shall be made by serving the Secretary of State as agent of the person.

2. Service of process shall be made pursuant to Section 2004 of Title 12 of the Oklahoma Statutes. The Insurance Commissioner shall not pay a fee. Persons served under the provisions of Sections 6103.1 through 6103.11 of this title shall not be considered foreign insurance companies.

B. Nothing contained in this section shall limit or abridge the right to serve any process upon any person in any other manner now or hereafter permitted by law.

Added by Laws 1994, c. 294, § 19, eff. Sept. 1, 1994. Amended by Laws 1997, c. 418, § 110, eff. Nov. 1, 1997.

§36-6103.10. Rulemaking.

The Insurance Commissioner may promulgate reasonable rules necessary to carry out the provisions of Sections 6103.1 through 6103.11 of this title.

Added by Laws 1994, c. 294, § 20, eff. Sept. 1, 1994. Amended by Laws 1997, c. 418, § 111, eff. Nov. 1, 1997.

§36-6103.11. Discretion to proceed under certain provisions.

The Insurance Commissioner may proceed solely under the provisions of Sections 6103.1 through 6103.11 of this title or under said provisions in conjunction with other applicable law. Added by Laws 1994, c. 294, § 21, eff. Sept. 1, 1994. Amended by Laws 1997, c. 418, § 112, eff. Nov. 1, 1997.

§36-6121. Permits required - Approval and denial of permit.

A. Any individual, firm, partnership, corporation, or association (hereinafter called "organization") which shall accept money or anything of value for prearranged, or prepaid funeral services, or funeral service merchandise as defined in the Funeral Services Licensing Act or for any contract providing future funeral services or funeral merchandise at a fixed price or at a cost plus a percentage, or at retail price less a percentage discount, or providing for any special consideration of any kind to be granted or made available to the purchaser or holder of such contract, in this state, under any sales contract, bond, certificate or other form of written document providing for prepaid, discounted or otherwise specially priced funeral or burial benefits or services or funeral merchandise to be delivered at an undetermined future date dependent upon the death of a contracting party or other person designated by a contracting party (hereinafter called "prepaid funeral benefits") shall first obtain a permit from the Insurance Commissioner authorizing the transaction of this type of business before entering into any such contract. It shall be unlawful to sell prepaid funeral benefits unless the seller holds a valid, current permit at the time the contract is made.

B. The Insurance Commissioner may deny the issuance of a permit if the organization:

1. Makes a material misstatement or misrepresentation in an application for a permit;

2. Fraudulently or deceptively obtains or attempts to obtain a permit for another; or

3. If any of its officers, owners, partners, or directors are determined by the Commissioner to not be competent, trustworthy, financially responsible, and of good personal and business reputation and character.

C. The Insurance Commissioner may approve an application of an organization for a permit and deny the request of the organization to act as a trustor if the organization does not satisfy all qualifications. This shall not hinder an organization from entering into contracts funded by assignments of insurance.

D. All permits issued pursuant to the provisions of this section shall be displayed in a conspicuous place at all times on the premises of the organization. No organization may consent to, or allow the use or display of, the permit by a person other than

the persons authorized to represent the organization in contracting prepaid funeral benefits.

E. The organization shall not be entitled to enforce a contract made in violation of the act, but the purchaser or the heirs of the purchaser, or legal representative, shall be entitled to recover triple the amounts paid to the organization with interest thereon at the rate of six percent (6%) per annum under any contract made in violation hereof.

Added by Laws 1970, c. 332, § 1. Amended by Laws 1988, c. 118, § 1, eff. Nov. 1, 1988; Laws 1989, c. 297, § 33, eff. Nov. 1, 1989; Laws 1993, c. 267, § 1, eff. Sept. 1, 1993; Laws 2009, c. 294, § 1, eff. Nov. 1, 2009; Laws 2016, c. 73, § 8, eff. Nov. 1, 2016.

§36-6122. Exemptions.

Nothing in Sections 6121 through 6135 of this title shall apply to religious or benevolent organizations, operating in this state as a burial association; or to the sale of lands or interests therein as grave lots, or grave spaces; burial or interment rights; delivered or installed crypts, niches or outer enclosures; or to cemetery merchandise sold pursuant to the provisions of the Cemetery Merchandise Trust Act.

Laws 1970, c. 332, § 2.

§36-6123. Administration of act - Contracts.

Sections 6121 through 6136.18 of this title shall be administered by the Insurance Commissioner. The Insurance Commissioner is authorized to prescribe reasonable rules and regulations concerning keeping and inspection of records, the filing of contracts and reports, and all other matters incidental to the orderly administration of this law; and the Insurance Commissioner shall first approve all forms for sale contracts for prepaid funeral benefits. All contracts for prepaid funeral benefits shall be in writing and no contract form shall be used without first being approved by the Insurance Commissioner. On any prepaid funeral when the person dies and the funeral is performed, and the money is drawn down, any organization receiving the monies so drawn down shall retain the itemized statement of charges in the files of the organization for at least six (6) years.

Added by Laws 1970, c. 332, § 3. Amended by Laws 1988, c. 118, § 2, eff. Nov. 1, 1988; Laws 2009, c. 294, § 2, eff. Nov. 1, 2009; Laws 2013, c. 269, § 11, eff. Nov. 1, 2013.

§36-6124. Acceptance of money for prepaid funeral benefits - Permit - Application.

A. Each organization desiring to accept money or anything of value for prepaid funeral benefits or an agreement to provide funeral benefits in the future at a fixed or predetermined cost,

shall file an application for a permit with the Insurance Commissioner, and shall at the time of filing an application pay one initial filing fee of Fifty Dollars (\$50.00). The Insurance Commissioner shall issue a permit upon:

1. The receipt of the application and payment of the filing fee;

2. Determination that the organization is in good standing as a funeral establishment with the Oklahoma Funeral Board; and

3. Making a finding that the organization has complied with the rules promulgated under this act by the Insurance Commissioner. All applications shall be signed by the organization requesting the permit, and shall contain a statement that the organization will comply with all the requirements as established by this act. All permits shall expire on December 31 of the year the permit is first issued, unless renewed; permits may be renewed for a period not to exceed the succeeding December 31 upon the payment of a renewal fee of Fifty Dollars (\$50.00). Late application for renewal of a permit shall require a fee of double the renewal fee. No application for renewal of a permit shall be accepted after January 31 of each year. The Insurance Commissioner may authorize acceptance of a new permit application pursuant to this section prior to the expiration of the one-year period upon good cause shown.

B. The Insurance Commissioner may cancel a permit or refuse to issue a permit or refuse to issue a renewal of a permit for failure to comply with any provision of this act, or any valid rule, which the Insurance Commissioner has promulgated, after reasonable notice to the organization and after hearing if the organization requests a hearing. When the Insurance Commissioner cancels a permit or refuses to issue a renewal of a permit for a violation as provided by this subsection, the Insurance Commissioner shall notify the Oklahoma Funeral Board of the action and the nature of any violations.

C. No organization shall be entitled to a new permit for a period of one (1) year after cancellation or refusal by the Insurance Commissioner to issue or renew the permit of the organization, but shall thereafter be entitled to a new permit upon satisfactory proof of compliance with this law after the expiration of the one-year period.

D. Any person or organization aggrieved by the actions of the Insurance Commissioner may appeal therefrom as provided by Article II of the Administrative Procedures Act.

Added by Laws 1970, c. 332, § 4. Amended by Laws 1984, c. 56, § 1, eff. July 1, 1984; Laws 1985, c. 328, § 22, emerg. eff. July 29, 1985; Laws 1988, c. 118, § 3, eff. Nov. 1, 1988; Laws 1993, c. 267, § 2, eff. Sept. 1, 1993; Laws 2003, c. 57, § 29, emerg. eff. April 10, 2003; Laws 2009, c. 294, § 3, eff. Nov. 1, 2009; Laws 2016, c. 73, § 9, eff. Nov. 1, 2016.

§36-6124.1. Transfer of prepaid funeral benefit permits -
Notification - Application.

A. No prepaid funeral benefit permit shall be transferable from one organization to another except as provided in this section. The selling organization shall notify the Insurance Commissioner at least forty-five (45) days prior to transfer of ownership. Notification shall be in a form provided by the Insurance Commissioner and shall contain at a minimum the following information:

1. The name of the acquiring organization;
2. The date the acquiring organization will take control of the funeral establishment;
3. A listing of all unrealized prepaid funeral benefit contracts funded by insurance assignments;
4. A listing of all unrealized prepaid funeral benefit contracts funded by trusts;
5. A detailed description of existing trusts to include, but not be limited to, the name of the contract holder and the trust value per contract; and
6. Any other information the Insurance Commissioner may request.

B. The Insurance Commissioner may waive the notice requirement provided for in subsection A of this section upon good cause shown.

C. The acquiring organization shall make application for a permit at least thirty (30) days prior to the transfer of ownership. Approval is contingent upon the organization receiving an establishment license as provided for in Sections 395.1 through 396.33 of Title 59 of the Oklahoma Statutes. The application shall include an assumption agreement executed by the acquiring organization in a form provided by the Insurance Commissioner.

D. The acquiring organization shall be issued a prepaid funeral benefit permit prior to the relinquishment of control of the trust by the selling organization. The acquiring organization shall not access funds held in the trust until authorization has been given by the Insurance Commissioner.

E. Upon good cause shown, the Insurance Commissioner may deny transfer of the trust from the selling organization to the acquiring organization.

F. The Insurance Commissioner may assume the role of acting trust conservator as a means of safeguarding the rights and interests of the individual contract holders or purchasers, their beneficiaries, successors, or personal representatives, or whenever necessary to protect the public welfare. The organization may make application to the Insurance Commissioner to draw down funds upon fulfillment of the prepaid funeral service contract.

G. Whenever a prepaid funeral benefit permit holder refuses to submit the books, records, papers and instruments of the prepaid funeral benefit contracts to the examination and inspection of the assistants or examiners of the Insurance Commissioner, or refuses or neglects to establish or maintain a prepaid funeral benefit permit in accordance with the requirements of the Prepaid Funeral Benefits Act within ninety (90) days after a written demand to establish or maintain a prepaid funeral benefit permit is made by the Commissioner, or in any manner obstructs or interferes with the examination of its prepaid funeral benefit contracts or refuses to be examined on oath concerning any of the affairs of its prepaid funeral benefit contracts, or for any other grounds listed in Article 18 or 19 of this title, the Commissioner may make application for receivership in the manner of a domestic insurer or take any other action pursuant to Articles 18 and 19, Sections 1901 through 1920 of this title.

H. The Insurance Commissioner may prescribe rules concerning matters incidental to this section.

I. For the purposes of Sections 6121 through 6136.18 of this title, "personal representative" means the person or persons designated by the purchaser of the contract for prepaid funeral benefits as having rights of ownership and control to the prepaid funds upon death of the purchaser; the guardian, executor, or the personal representative of the estate of the purchaser; or the claiming successor or successors establishing lawful right to the prepaid funds in accordance with Section 393 of Title 58 of the Oklahoma Statutes.

Added by Laws 2009, c. 294, § 4, eff. Nov. 1, 2009. Amended by Laws 2016, c. 118, § 1, eff. Nov. 1, 2016; Laws 2024, c. 345, § 15, eff. Nov. 1, 2024.

§36-6124.2. Application for change of name of a prepaid funeral benefit permit holder.

A. No prepaid funeral benefit permit holder shall change the name under which the permit holder operates except as provided in this section. The prepaid funeral benefit permit holder shall obtain approval from the Insurance Commissioner at least thirty (30) days prior to changing the name of the permit holder. The application for change of name of a prepaid funeral benefit permit holder shall be in a form provided by the Insurance Commissioner and shall contain, at a minimum, the following information:

1. The name of the permit holder;
2. The proposed new name of the permit holder; and
3. The date the name change will become effective.

B. The Insurance Commissioner may waive the approval requirement provided for in subsection A of this section upon good cause shown.

C. The Insurance Commissioner may deny the change of name of the prepaid funeral benefit permit holder upon good cause shown.

D. Upon approval of a change of name, the Insurance Commissioner shall issue a prepaid funeral benefit permit with the new name. The prepaid funeral benefit permit holder shall display in a conspicuous place at all times on the premises of the organization all permits issued pursuant to the provisions of this section. No organization may consent to or allow the use or display of the permit by a person other than the persons authorized to represent the organization in contracting prepaid funeral benefits.

E. The Insurance Commissioner may prescribe rules concerning matters incidental to this section.

Added by Laws 2021, c. 478, § 30, emerg. eff. May 12, 2021.

§36-6125. Deposit and investment of funds - Transfer of funds - Types of contracts - Net value of contract - Interest - Withdrawal of funds - Disbursement statement - Bond - Administrative fee - Acceptance of funds - Violations.

A. 1. The organization may retain from the first funds collected, the first ten percent (10%) of the purchase price of all contracts issued pursuant to paragraph 1 of subsection B of this section. Thereafter, one hundred percent (100%) of all funds collected pursuant to the provisions of contracts for prepaid funeral benefits, except for outer enclosures as defined by the Funeral Services Licensing Act, shall be placed in investments authorized by Article 16 of the Insurance Code, except to the extent the Insurance Commissioner may determine that a particular asset may be inappropriate for investment for prepaid funeral benefits.

2. For outer enclosures at the option of the organization the first thirty-five percent (35%) of the retail price of the outer enclosures collected may be retained by the organization. The remaining sixty-five percent (65%) of the retail price collected for the outer enclosures shall be invested as otherwise provided by this subsection pursuant to the provisions of contracts for prepaid funeral benefits.

3. The funds required to be deposited pursuant to paragraphs 1 and 2 of this subsection shall be deposited within ten (10) days after the collection of the funds and shall be held in a trust fund in this state for the use, benefit, and protection of purchasers of contracts for prepaid funeral benefits. Nothing contained within this section shall be construed to prohibit an organization authorized to accept prepaid funds from transferring the funds held in trust from one trust depository to another if notice of the transfer is given to the Insurance Commissioner within ten (10) days before the transfer and the organization transferring the funds remains the designated trustor. This subsection shall not affect funds invested prior to November 1, 1988.

B. An organization authorized to accept prepaid funds shall be authorized to provide purchasers with a choice of either of the following types of contracts:

1. A contract for Specific and Described Funeral Merchandise and Service at a Guaranteed Price. The provisions of this type of contract shall provide that interest paid by the organization upon monies deposited in trust shall be added to the principal and that principal and interest shall become available for disbursement to the organization upon the death of the beneficiary and if withdrawal of monies occurs prior to death, the net value, plus the amount withheld pursuant to paragraph 1 of subsection A of this section, shall be paid to the purchaser. Net value of the contract for purposes of this section shall be determined by adding the amount of all principal paid in pursuant to the provisions of the contract plus all interest payable pursuant to subsection D of this section less taxes and administrative fees;

2. A contract establishing a fund for prepaid funeral benefits. The provisions of this type of contract shall require an initial minimum deposit of Twenty-five Dollars (\$25.00) and shall grant the purchaser the right to add to the fund at the discretion of the purchaser. The provisions of this contract shall provide that the funds accumulated shall apply to the cost of the funeral services and merchandise selected and that any funds remaining unused shall be refunded to the purchaser or to the personal representative or designated beneficiary of the purchaser and if withdrawal of monies occurs prior to death, the organization may retain from the interest, all interest incurred in excess of the minimum amount payable pursuant to subsection D of this section less taxes and administrative fees. This type of contract shall also bear upon it the language: "Exact Funeral Merchandise and Services to be Selected at Time of Death";

3. Notwithstanding the provisions of this section, at no time shall the purchaser of a contract for Specific and Described Funeral Merchandise and Service at a Guaranteed Price receive upon any withdrawal or transfer a sum less than the original principal collected; or

4. Notwithstanding the provisions of this section, at no time shall the purchaser of a contract for Exact Funeral Merchandise and Services to be Selected at Time of Death receive upon any full withdrawal or transfer prior to death a sum less than the original principal collected available at death, with the exception of those accounts which bear principal reduced by previously made cash withdrawals.

C. If an organization other than the organization with which the purchaser contracted provides funeral merchandise and services upon the death of the beneficiary of the contract, the organization with whom the purchaser contracted shall forward, upon receipt of

request in writing from the purchaser or the personal representative of the purchaser, the net value of the contract plus the amount withheld pursuant to paragraph 1 of subsection A of this section to the organization which provided the merchandise and services or to the purchaser or the personal representative of the purchaser.

D. Funds deposited in trust pursuant to the provisions of either type of contract authorized by the provisions of this section shall earn for the account of the purchaser a rate of interest which is not less than the minimum rate of interest offered by the qualified investments specified in subsection A of this section to the savings customers of the qualified investments having interest-bearing accounts. The organization, in a nondiscriminatory manner, may pay or accrue interest for the accounts of purchasers at any rate greater than the minimum rate that the organization desires; provided, however, that the organization may retain from the interest all interest incurred in excess of the minimum amount payable pursuant to this subsection.

E. A purchaser of either of the types of contracts authorized by the provisions of this section may withdraw the net value of the contract by signing a statement requesting the withdrawal. The organization shall retain in its files a copy of the statement requesting the withdrawal. Withdrawal of funds deposited pursuant to the provisions of a contract authorized by the provisions of paragraph 1 of subsection B of this section shall void the obligation of the contracting organization to provide funeral merchandise and services at a guaranteed price. Withdrawal forms shall be retained on file for at least six (6) years by the organization.

F. Following the death of a beneficiary for whom a contract has been purchased, the organization shall prepare a statement, acknowledged by the purchaser if the purchaser is not the beneficiary, or by the personal representative of the purchaser if the purchaser is the beneficiary, setting forth the use of the funds deposited and the party to whom any unused funds were disbursed. A copy of this statement shall remain in the files of the organization for at least six (6) years and a copy shall be delivered to the trust depository and the purchaser.

G. After thirty (30) days, a contract of either type authorized by the provisions of this section may become irrevocable and not subject to withdrawal prior to the death of the beneficiary if the purchaser signs an election making the contract irrevocable. This election shall not become effective until thirty (30) days after signing the original contract.

H. In no event shall more funds be withdrawn or paid pursuant to the provisions of one contract than were deposited with the organization and which were accumulated as interest. All funds deposited pursuant to the provisions of a contract authorized by the

provisions of this section and deposited pursuant to the terms of this section and the interest earned on the funds shall be exempt from attachment, garnishment, execution, and the claims of creditors, receivers, or trustees in bankruptcy, until the time the funds have been withdrawn from the trust account and paid to the organization or refunded to the purchaser.

I. Each organization subject to the provisions of this section shall furnish a bond in the form of a cash bond, letter of credit, or fidelity bond, to be approved by the Insurance Commissioner, in the amount of Three Hundred Thousand Dollars (\$300,000.00) or fifteen percent (15%) of all funds collected for prepaid funeral benefits, whichever is less.

J. Organizations contracting with purchasers for prepaid funeral benefits pursuant to paragraphs 1 and 2 of subsection B of this section shall be entitled to deduct from the principal and interest allocable to the contracts an administrative fee which shall not exceed the product of .001146 times the total contract fund including accrued interest per month or any major portion thereof.

K. No organization holding a permit issued pursuant to the provisions of Sections 6121 and 6124 of this title shall accept any funds except pursuant to the provisions of a contract for prepaid funeral or burial benefits authorized by the provisions of Sections 6121 through 6136.18 of this title, and no organization shall accept funds from a purchaser in excess of the contracted price of prepaid funeral or burial benefits purchased.

L. Any organization which knowingly commits any of the acts set forth in the first sentence of Section 6121 of this title without first having obtained a permit to engage in the stated activity from the Insurance Commissioner, or any organization which commits the acts while knowingly operating with an invalid or expired permit, upon conviction, shall be guilty of a misdemeanor. Each separate act performed without a valid permit shall be deemed a separate offense. The punishment upon conviction for the offense shall be a fine not to exceed One Thousand Dollars (\$1,000.00) or imprisonment in the county jail for not less than sixty (60) days nor more than one (1) year, or both such fine and imprisonment.

Added by Laws 1970, c. 332, § 5. Amended by Laws 1975, c. 83, § 1; Laws 1980, c. 277, § 1, emerg. eff. June 13, 1980; Laws 1983, c. 245, § 1, operative Sept. 1, 1983; Laws 1984, c. 56, § 2, eff. July 1, 1984; Laws 1988, c. 118, § 4, eff. Nov. 1, 1988; Laws 1989, c. 297, § 35, eff. Nov. 1, 1989; Laws 1990, c. 195, § 1, emerg. eff. May 10, 1990; Laws 1993, c. 267, § 3, eff. Sept. 1, 1993; Laws 2009, c. 294, § 5, eff. Nov. 1, 2009; Laws 2013, c. 269, § 12, eff. Nov. 1, 2013; Laws 2016, c. 118, § 6, eff. Nov. 1, 2016; Laws 2018, c. 171, § 1, eff. Nov. 1, 2018.

§36-6125.1. Maximum amount of principal an organization may receive pursuant to insurance contract.

A. The maximum amount of principal which an organization may legally receive from any one individual pursuant to a contract establishing a fund for prepaid funeral benefits pursuant to paragraph 2 of subsection B of Section 6125 of this title shall be Twenty Thousand Dollars (\$20,000.00).

B. The maximum allowable amount of principal for subsequent years shall be increased annually by a percentage equal to the previous year's increase in the national Consumer Price Index (CPI). The Insurance Commissioner shall determine the amount of the increase, if any, on April 1 of each year.

Added by Laws 1988, c. 118, § 7, eff. Nov. 1, 1988. Amended by Laws 2000, c. 113, § 1, eff. July 1, 2000 and by Laws 2000, c. 353, § 44, eff. Nov. 1, 2000; Laws 2010, c. 354, § 1, eff. Nov. 1, 2010.

NOTE: Laws 2000, c. 113, § 1 and Laws 2000, c. 353, § 44 contain duplicate amendments.

§36-6125.2. Funding of contract by assignment of life insurance proceeds.

A. Contracts for prepaid funeral benefits provided for pursuant to Section 6125 of this title may be funded by assignments of life insurance proceeds to the contracting organization.

B. A guaranteed contract for prepaid funeral benefits provided for pursuant to paragraph 1 of subsection B of Section 6125 of this title which is to be funded by assignment of life insurance proceeds shall provide that:

1. The contract be funded by a life insurance policy issued in the face amount of the current purchase price of the contract for prepaid funeral benefits;

2. All accrued benefits under the policy shall become available for disbursement to the organization upon the death of the beneficiary of the prepaid funeral contract;

3. The beneficiary shall be the same individual under the contract as the insured under the life insurance policy; and

4. The disbursement of life insurance proceeds to the organization shall constitute payment in full to the organization for the services and merchandise contracted for.

C. A nonspecified contract for prepaid funeral benefits provided for pursuant to paragraph 2 of subsection B of Section 6125 of this title which is to be funded by assignment of life insurance proceeds shall provide that:

1. The total proceeds paid to the organization under the policy shall not exceed the actual retail cost of the funeral services and merchandise at the time of delivery;

2. Any funds remaining unused shall be refunded to the purchaser or to the personal representative of the purchaser or designated beneficiary; and

3. After November 1, 2009, all price lists reflecting the actual retail cost of funeral services and merchandise used at the time of the delivery of services shall be retained for a period of at least six (6) years.

D. A violation of this section shall constitute a misdemeanor and shall be punished by a fine of not less than One Hundred Dollars (\$100.00) nor more than Five Hundred Dollars (\$500.00) or by imprisonment in the county jail for not less than one (1) month nor more than six (6) months, or by both such fine and imprisonment. Added by Laws 1988, c. 118, § 8, eff. Nov. 1, 1988. Amended by Laws 2009, c. 294, § 6, eff. Nov. 1, 2009; Laws 2013, c. 269, § 13, eff. Nov. 1, 2013.

§36-6126. Designation of agent.

A. Each organization subject to the Funeral Services Licensing Act shall designate an agent or agents, either by names of the individuals or by titles of the offices or positions of the individuals, who shall be responsible for deposits of funds collected under contract for prepaid funeral benefits. The organization shall notify the Insurance Commissioner of the designation at least ten (10) days prior to becoming subject to this act, and shall also notify the Insurance Commissioner of any changes in the designation at least ten (10) days before the change occurs.

B. Any person collecting monies under a contract on behalf of an organization shall deposit the monies within ten (10) days after collection pursuant to paragraph 3 of subsection A of Section 6125 of this title. Any person failing to deposit the monies collected shall be guilty of a misdemeanor and shall be punished by a fine of not less than One Hundred Dollars (\$100.00) nor more than Five Hundred Dollars (\$500.00) or by imprisonment in the county jail for not less than one (1) month nor more than six (6) months, or by both such fine and imprisonment. Added by Laws 1970, c. 332, § 6. Amended by Laws 2009, c. 294, § 7, eff. Nov. 1, 2009.

§36-6127. Merchandise price display.

Any organization or person offering for sale caskets or other articles of merchandise incidental to burial or funeral services shall prominently display thereon the retail price of said caskets, or other articles of merchandise. Amended by Laws 1983, c. 245, § 2, operative Sept. 1, 1983.

§36-6128. Annual report.

Each organization shall file an annual report with the Insurance Commissioner on or before March 15 of each year in such form as the Insurance Commissioner may require, showing the names and addresses of all persons with whom contracts for prepaid funeral benefits have been made prior to December 31 of the preceding year which had not been fully discharged on December 31 and, also showing the date of the contract, the name of the bank or depository holding the trust fund and the amount of the trust fund under each contract on the preceding December 31. Any organization which has discontinued the sale of prepaid funeral benefits, but which still has outstanding contracts, shall not be required to obtain a renewal of its permit, but it shall continue to make annual reports to the Insurance Commissioner until all such contracts have been fully discharged. A filing fee of Fifty Dollars (\$50.00) shall accompany each report. If any officer of any organization fails or refuses to file an annual report, or to cause it to be filed within thirty (30) days after he has been notified by the Insurance Commissioner that the report is due and has not been received, he shall be guilty of a misdemeanor and shall be punished as prescribed in Section 6130 of this title.

Amended by Laws 1984, c. 56, § 3, eff. July 1, 1984; Laws 1988, c. 118, § 5, eff. Nov. 1, 1988.

§36-6129. Records - Annual statement of financial condition.

Each organization which has outstanding contracts for prepaid funeral benefits shall maintain within this state such records as the Insurance Commissioner may require to enable the Insurance Commissioner to determine whether the organization is complying with the provisions of Sections 6121 through 6136 of this title. Each organization shall provide to the Insurance Commissioner an annual statement of the financial condition of funds collected pursuant to contracts for prepaid funeral benefits. The statement shall be due by the fifteenth day of March of each year and shall reflect, at a minimum, the assets and liabilities of each prepaid funeral benefits fund and the location and status of all trust funds for prepaid funeral benefits as of the last day of December of the preceding year. Failure to file an annual statement by the date required may result in censure, or suspension or revocation of license, and an administrative penalty imposed by the Insurance Commissioner of from One Hundred Dollars (\$100.00) to One Thousand Dollars (\$1,000.00) for each occurrence.

Laws 1970, c. 332, § 9; Laws 1983, c. 245, § 3, operative Sept. 1, 1983; Laws 1984, c. 56, § 4, eff. July 1, 1984; Laws 1988, c. 118, § 6, eff. Nov. 1, 1988; Laws 1993, c. 267, § 4, eff. Sept. 1, 1993.

§36-6129.1. Annual financial examination of trusts and accounts.

Annually, on or before the fifteenth day of March, and whenever the Insurance Commissioner deems it to be prudent or necessary, each organization operating one or more prepaid funeral trusts shall have a financial examination of each trust and related prepaid funeral accounts for the preceding calendar year, prepared by a licensed public accountant or certified public accountant and in accordance with procedures promulgated by the Insurance Commissioner's office. The examination also shall evaluate and report on the compliance of each trust with the provisions of Section 6121 et seq. of Title 36 of the Oklahoma Statutes, relating to prepaid funeral benefits. Added by Laws 1993, c. 267, § 5, eff. Sept. 1, 1993.

§36-6130. Violations and penalties.

A. Any officer, director, agent, or employee of any organization subject to the terms of Sections 6121 through 6136.18 of this title who makes or attempts to make any contract in violation of the provisions of Sections 6121 through 6136.18 of this title, or who refuses to allow an inspection of the records of the organization, or who violates any other provision of Sections 6121 through 6136.18 of this title, upon conviction, shall be guilty of a felony and shall be punished by imprisonment in the custody of the Department of Corrections for a term of not more than ten (10) years, and a fine not exceeding Ten Thousand Dollars (\$10,000.00), and ordered to pay restitution to the victim. Each violation of any provision of Sections 6121 through 6136.18 of this title shall be deemed a separate offense and prosecuted individually.

B. The violation of any provision of Sections 6121 through 6136.18 of this title shall constitute a cause for the Oklahoma Funeral Board to revoke, or to refuse to issue or renew, any license issued pursuant to the provisions of Sections 396 through 396.33 of Title 59 of the Oklahoma Statutes. The violation of any provision of Sections 6121 through 6136.18 of this title shall constitute a cause for the Insurance Commissioner to issue a notice and order to show cause why the licensee shall not be censured, have the license of the licensee suspended or revoked, be subject to a fine of not less than One Hundred Dollars (\$100.00) and not more than One Thousand Dollars (\$1,000.00), or be subject to both such fine and punishment.

Added by Laws 1970, c. 332, § 10. Amended by Laws 1983, c. 245, § 4, operative Sept. 1, 1983; Laws 1985, c. 328, § 23, emerg. eff. July 29, 1985; Laws 2007, c. 125, § 22, eff. July 1, 2007; Laws 2009, c. 294, § 8, eff. Nov. 1, 2009.

§36-6131. Misquoting requirements of law - Penalty.

Any person who deals with the disposal or burial of deceased persons who wilfully misquotes requirements of state law regarding such shall be guilty of a misdemeanor.

Laws 1970, c. 332, § 11.

§36-6133. Repealed by Laws 2009, c. 432, § 27, eff. July 1, 2009.

§36-6134. Certain advertising not prohibited.

Nothing in this act or any other law of the State of Oklahoma shall be construed to prevent or prohibit advertising of the price or any other information relating to the sale of any funeral service, funeral benefit, funeral merchandise, or any other property which may be used in the burial or disposal of the human dead, provided such advertising shall not be false, fraudulent or misleading.

Laws 1970, c. 332, § 14.

§36-6135. Insurance Code not affected.

Nothing in this act shall alter or affect any provision of the Insurance Code of the State of Oklahoma.

Laws 1970, c. 332, § 15.

§36-6136.18. Conversion from trust-funded to insurance-funded benefits.

A. Member organizations may convert trust-funded prepaid funeral benefits to insurance-funded prepaid funeral benefits. The conversion shall be subject to the provisions of Section 6125.2 of this title.

B. The Insurance Commissioner shall approve a conversion from trust-funded prepaid funeral benefits to insurance-funded prepaid funeral benefits as safeguarding the rights and interests of the individual who purchases the prepaid funeral benefits contract.

C. The Commissioner shall prescribe rules detailing the steps necessary to complete the conversion of prepaid funeral benefit contracts funded by a trust to prepaid funeral benefits contracts funded by insurance.

Added by Laws 1999, c. 226, § 1, emerg. eff. May 26, 1999. Amended by Laws 2009, c. 294, § 9, eff. Nov. 1, 2009.

§36-6141. Short title.

Sections 1 through 17 of this act shall be known and may be cited as the "Prepaid Dental Plan Act".

Added by Laws 1983, c. 66, § 1, eff. Nov. 1, 1983.

§36-6142. Definitions.

As used in the Prepaid Dental Plan Act:

1. "Member" means an individual who is enrolled in a group prepaid dental plan as a principal subscriber, and dependents who are entitled to dental care services under the plan solely because of their status as dependents of the principal subscriber.

2. "Membership coverage" means any certificate or contract issued to a member specifying the dental coverage to which said member is entitled.

3. "Prepaid dental plan" means any contractual arrangement whereby any prepaid dental plan organization undertakes to provide payment of dental services directly, or to arrange for prepaid dental services, or to pay or make reimbursement for any dental services not provided for by other insurance.

4. "Prepaid dental plan organization" means any person who undertakes to conduct one or more prepaid dental plans providing only dental services.

5. "Prepaid dental services" means services included in the practice of dentistry in all of its branches as defined in Section 328.3 of Title 59 of the Oklahoma Statutes.

6. "Provider" means any person licensed or otherwise authorized to furnish prepaid dental services in this state other than an authorized insurer.

Added by Laws 1983, c. 66, § 2, eff. Nov. 1, 1983.

§36-6143. Certificate of authority required.

A. No person unless authorized pursuant to the provisions of Section 4 or Section 10 of this act shall establish or operate a prepaid dental plan organization in this state, or sell or offer to sell, or solicit offers to purchase, or receive advance or periodic consideration, in conjunction with a prepaid dental plan without obtaining and maintaining a certificate of authority issued pursuant to Section 4 of this act.

B. On or before February 1, 1984, every prepaid dental plan organization operating in this state shall submit an application for a certificate of authority to the Commissioner. Each applicant may continue to operate as an organization until the Commissioner acts upon the application.

Added by Laws 1983, c. 66, § 3, eff. Nov. 1, 1983.

§36-6144. Application for certificate of authority.

A. An application for a certificate of authority to operate as a prepaid dental plan organization shall be filed with the Commissioner in a form prescribed by the Commissioner. The application shall be verified by an officer or authorized representative of the applicant, and shall set forth or be accompanied by:

1. A copy of any basic organizational document of the applicant such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, with all amendments to such documents;

2. A copy of any bylaws, rules or regulations, or similar documents regulating the conduct of the internal affairs of the applicant;

3. A list of the names, addresses, and official positions of the persons who are responsible for the conduct of the business affairs of the applicant, including all members of the board of directors, board of trustees, executive committee or other governing board or committee, and the principal officers in the case of a corporation, and the partners or members in the case of a partnership or association;

4. A copy of any contract made or to be made between any providers of dental services or persons listed in paragraph 3 of this subsection and the applicant;

5. A statement generally describing the prepaid dental plan organization, all prepaid dental plans offered by said organizations, and facilities, and personnel;

6. A copy of the form of individual or group membership coverage or a copy of the contract to be issued to the members;

7. Financial statements showing assets, liabilities, and sources of financial support of the applicant. If the financial affairs of the applicant are audited by independent certified public accountants, a copy of the most recent regular certified financial statement for the applicant shall satisfy this requirement unless the Commissioner determines that additional or more recent financial information is required;

8. A description of the proposed method of marketing the prepaid dental plan, a financial prospectus which includes a three-year projection of the initial operating results anticipated, and a statement as to the sources of working capital available for the operation of the prepaid dental plan as well as any other sources of funding;

9. A power of attorney, duly executed by said applicant if not domiciled in this state appointing the Commissioner, as the true and lawful representative for service of process for said applicant in this state, upon whom all lawful process in any legal action or proceeding against the prepaid dental plan organization on a cause of action arising in this state may be served;

10. A fee of One Hundred Dollars (\$100.00) for issuance of a certificate of authority; and

11. Such other information as the Commissioner may require.

B. Within ten (10) days following any said modification of information previously furnished as required by subsection A of this section, a prepaid dental plan organization shall file notice of said modification with the Commissioner.

Added by Laws 1983, c. 66, § 4, eff. Nov. 1, 1983. Amended by Laws 2009, c. 432, § 20, eff. July 1, 2009.

§36-6145. Issuance of certificate of authority - Conditions.

A. Issuance of a certificate of authority for a prepaid dental plan organization shall be granted by the Commissioner if the Commissioner is satisfied that the following conditions are met:

1. The persons responsible for conducting the business affairs of the prepaid dental plan organization are competent and trustworthy and are professionally capable of providing or arranging for the provision of services offered; and

2. The prepaid dental plan organization constitutes an appropriate mechanism to achieve an effective prepaid dental plan; and

3. Each officer, responsible for conducting the business affairs of the prepaid dental plan organization, has filed with the Commissioner a fidelity bond in the amount of Fifty Thousand Dollars (\$50,000.00), said bond to be subject to the approval of the Commissioner; and

4. The financial structure of the prepaid dental plan organization may reasonably be expected to meet obligations for payment of services for members and prospective members. In making this determination the Commissioner may consider:

a. the financial soundness of the arrangements made pursuant to the provisions of the prepaid dental plan for services and the schedule of charges used; and

b. any agreement with an insurer, a hospital, a medical service corporation, or any other organization for ensuring the payment of prepaid dental services; and

c. provisions in the plan for automatic coverage of dental service if the prepaid dental plan is discontinued; and

d. the sufficiency of the agreement for prepaid dental services with providers of dental services.

B. A certificate of authority shall expire at midnight on June 30, following the date of issuance or last renewal date. If the prepaid dental plan organization remains in compliance with the provisions of the Prepaid Dental Plan Act and pays a renewal fee of One Hundred Dollars (\$100.00), the certificate of authority of said plan may be renewed. The renewal fee shall be deposited in the Insurance Commissioner Revolving Fund.

Added by Laws 1983, c. 66, § 5, eff. Nov. 1, 1983.

§36-6146. Deposit required.

A. A prepaid dental plan organization shall keep on deposit with the Insurance Commissioner cash certificates of deposit issued by solvent insured banks and trust companies in Oklahoma, or a combination of cash certificates or securities eligible for investment of capital funds, which have been approved by the Commissioner in the following amounts:

Number of members	Deposit
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5,000 or less	\$25,000.00
5,001 - 7,500	\$30,000.00
7,501 - 10,000	\$50,000.00
10,001 - 15,000	\$75,000.00
15,001 - 20,000	\$100,000.00
20,001 - 25,000	\$125,000.00
25,001 - 30,000	\$150,000.00
30,001 - 40,000	\$175,000.00
40,001 and above	\$200,000.00

B. The deposit required by the provisions of subsection A of this section shall be held by the Commissioner in trust for the benefit and protection of persons covered by a prepaid dental plan and shall not be subject to attachment by any creditors of the prepaid dental organization or plan.

C. Any securities required by the provisions of subsection A of this section, with the approval of the Commissioner, may be exchanged for similar securities or cash of equal amount. Interest on securities deposited shall be payable to the prepaid dental plan organization depositing such securities.

D. An unpaid final judgment arising upon a membership coverage shall be a lien on the deposit held by the Commissioner, subject to execution after thirty (30) days from the entry of final judgment, unless the judgment is satisfied. If the deposit held by the Commissioner is reduced, the deposit shall be replenished within ninety (90) days by the prepaid dental plan organization.

E. The deposit prescribed by the provisions of subsection A of this section shall not apply to a prepaid dental plan organization which is funded by the state, a political subdivision of the state, or the United States.

F. Upon liquidation or dissolution of a prepaid dental plan organization and the satisfaction of all debts and liabilities of the organization, any balance remaining of the cash or securities deposit as prescribed in subsection A of this section together with any other assets of the prepaid dental plan organization shall be returned by the Commissioner to the prepaid dental plan organization.

Added by Laws 1983, c. 66, § 6, eff. Nov. 1, 1983. Amended by Laws 2014, c. 275, § 18, eff. Nov. 1, 2014.

§36-6147. Financial reserve.

A. A prepaid dental plan organization shall maintain, for protection of members, a financial reserve consisting of at least two percent (2%) of all prepaid charges collected from members for the prepaid dental plan, until said reserve totals Five Hundred Thousand Dollars (\$500,000.00). This reserve shall be in addition to the deposit prescribed by Section 6 of this act.

B. The reserve prescribed by this section shall not apply with respect to a prepaid dental plan organization which is funded by the state, a political subdivision of the state, or the United States. Added by Laws 1983, c. 66, § 7, eff. Nov. 1, 1983.

§36-6148. Policy for membership coverage.

A. Every member in a prepaid dental plan shall be issued a membership coverage policy by the prepaid dental plan organization.

B. No policy for membership coverage or amendment to said policy shall be issued or delivered to any person in this state until a copy of the policy for membership coverage or amendment to said policy has been filed with and approved by the Commissioner.

C. A policy for membership coverage shall contain a statement of:

1. The prepaid dental services or other benefits to which the member is entitled under the prepaid dental plan; and

2. Any limitations of the services or benefits to be provided, including any deductible or co-payment feature; and

3. Information as to how services may be obtained; and

4. The obligation of the member for charges for the prepaid dental plan.

D. Any member in a prepaid dental plan shall be free to select any licensed dental practitioner to provide dental services and prepayment or reimbursement determinations shall be made without regard to whether the provider is a participating or nonparticipating member of the plan. This provision shall be printed on the policy for membership coverage.

E. Membership coverage shall contain no provisions or statements which are unjust, unfair, untrue, inequitable, misleading, deceptive, or which encourage misrepresentation as determined by the Commissioner.

F. The Commissioner shall approve any policy of membership coverage if the requirements of this section are complied with and the prepaid dental plan, in the judgment of the Commissioner, is able to meet its financial obligations for the membership coverage. It shall be unlawful for a prepaid dental plan organization to issue a policy until approved. If the Commissioner does not disapprove any such policy within thirty (30) days after filing, said policy shall be deemed approved. If the Commissioner disapproves a policy of membership coverage, the Commissioner shall notify the prepaid dental plan organization, specifying the reasons for disapproval. The Commissioner shall grant a hearing on such disapproval within thirty (30) days after a request in writing for a hearing is received by the Commissioner from the prepaid dental plan organization.

Added by Laws 1983, c. 66, § 8, eff. Nov. 1, 1983.

§36-6149. Annual business report.

A. Each year on or before March 1, every prepaid dental plan organization shall file with the Commissioner a report of the business activities of said organization for the preceding calendar year. This report shall be signed by at least two principal officers of the corporation and said signatures shall be notarized.

B. Said reports shall be on forms prescribed by the Commissioner and shall include:

1. A financial statement of the organization, including a copy of the balance sheet and receipts and disbursements of the organization for the preceding year certified by an independent certified public accountant. The Commissioner may accept a full report of the most recent examination of a foreign prepaid dental plan, certified to by the appropriate examining official of another state; and

2. Any material changes in the information required to be provided pursuant to Section 5 of this act; and

3. The number of persons who have become members during the preceding year, the total number of members in the plan as of the end of the year, and the number of memberships terminated during the year; and

4. The costs of all care provided and the number of members who received care pursuant to the provisions of the prepaid dental plan; and

5. Such other information relating to the performance of the prepaid dental plan organization the Commissioner deems necessary to enable the Commissioner to carry out the duties prescribed by the Prepaid Dental Plan Act.

Added by Laws 1983, c. 66, § 9, eff. Nov. 1, 1983.

§36-6150. Payment of taxes.

A. Coincident with the filing of the annual report prescribed by Section 9 of this act, each prepaid dental plan organization shall pay to the State Treasurer through the Commissioner a tax for transacting a prepaid dental plan. The obligation shall be determined as follows:

1. If a domestic organization, two percent (2%) of prepaid net charges received from members in this state.

2. If a foreign organization, two percent (2%) of prepaid net charges received from members in this state.

B. An organization may offset this tax in whole or in part by payment of state corporate income tax, as provided for in Section 2355 of Title 68 of the Oklahoma Statutes. However, an organization shall not be able to carry over to a succeeding year any credit for paying corporate income tax not used during a year.

Added by Laws 1983, c. 66, § 11, eff. Nov. 1, 1983.

§36-6151. Unfair trade practices and fraud.

Article 12 of Title 36 of the Oklahoma Statutes relating to unfair trade practices and frauds shall apply to prepaid dental plan organizations, except to the extent the Commissioner may determine that particular provisions of said article shall not apply to prepaid dental plan organizations.

Added by Laws 1983, c. 66, § 11, eff. Nov. 1, 1983.

§36-6152. Repealed by Laws 1997, c. 418, § 125, eff. Nov. 1, 1997.

§36-6153. Examination of business affairs of prepaid dental plan organization.

The Commissioner may conduct an examination of the business affairs of any prepaid dental plan organization as often as the Commissioner deems necessary for the protection of the interests of the people of this state.

Added by Laws 1983, c. 66, § 13, eff. Nov. 1, 1983.

§36-6154. Suspension or revocation of certificate of authority.

A. The Commissioner may suspend or revoke any certificate of authority issued to a prepaid dental plan organization pursuant to the provisions of the Prepaid Dental Plan Act if the Commissioner finds that any of the following conditions exist:

1. The prepaid dental plan organization is operating contrary to the basic organizational documents of the organization or is operating in a manner contrary to that described in, and reasonably inferred from, any other information submitted pursuant to Section 6144 of this title;

2. The prepaid dental plan organization issued membership coverage which does not comply with the requirements of Section 6148 of this title;

3. The prepaid dental plan does not provide or arrange for basic dental services appropriate to a prepaid dental plan;

4. The prepaid dental plan organization can no longer be expected to meet obligations to members or prospective members of the prepaid dental plan;

5. The prepaid dental plan organization, or any authorized person acting on behalf of the organization, has advertised or merchandised services offered by said organization in an untrue, misleading, deceptive, or unfair manner;

6. The prepaid dental plan organization fails to deal equitably with any dentists, dental physicians, technicians, or other persons or facilities whose services are covered within a contract or policy for prepaid dental insurance; or

7. The prepaid dental plan organization has failed to substantially comply with the provisions of the Prepaid Dental Plan Act or any rules and regulations promulgated thereunder.

B. When the certificate of authority of a prepaid dental plan organization is suspended, the organization shall not accept, during the period of such suspension, any additional members except newly acquired dependents of existing members and shall not engage in any advertising or solicitation.

C. When the certificate of authority of a prepaid dental plan organization is revoked, the organization shall proceed to terminate operation of the organization immediately and shall conduct no further business except as may be essential to the orderly conclusion of the business affairs of the organization. The Commissioner, by written order, may permit such further operation of the organization as the Commissioner finds to be in the best interest of members of the organization.

D. If a certificate of authority is suspended or revoked pursuant to the provisions of this section, the Commissioner may invoke a fine not exceeding One Thousand Dollars (\$1,000.00) for each violation. The payment of the fine may be enforced in the same manner as civil judgments may be enforced.

E. A prepaid dental plan organization which has had its certificate of authority denied, suspended, or revoked, or has suffered an adverse decision by the Commissioner, shall be entitled to a hearing pursuant to the provisions of the Administrative Procedures Act, Sections 301 through 326 of Title 75 of the Oklahoma Statutes.

Added by Laws 1983, c. 66, § 14, eff. Nov. 1, 1983. Amended by Laws 2009, c. 432, § 21, eff. July 1, 2009.

§36-6155. Rehabilitation, liquidation, or conservation of prepaid dental plan organization.

Any rehabilitation, liquidation, or conservation of a prepaid dental plan organization shall be conducted pursuant to the provisions for rehabilitation, liquidation, or conservation of an insurer provided for by Articles 18 and 19 of Title 36 of the Oklahoma Statutes.

Added by Laws 1983, c. 66, § 15, eff. Nov. 1, 1983.

§36-6156. Advertising or sales material.

A. No advertising or sales material relating to a prepaid dental plan organization shall be issued or delivered to any person in this state until a copy of said material has been filed with and approved by the Commissioner. Within thirty (30) days after submission of said advertising or sales material, the Commissioner shall either approve the advertising or sales material, or shall disapprove it should he determine that in whole or in part said material is false, deceptive, or misleading. If the Commissioner disapproves any advertising or sales material he shall give written notification to the person who submitted the material. Thereafter,

such advertising or sales material shall not be used by any person. Violation of the provisions of this subsection shall entitle the Commissioner in his discretion and without additional cause to withdraw approval of any membership coverage with respect to which said advertising or sales material is used.

B. Offers to sell prepaid dental insurance by advertising or publication of material by prepaid dental plan organizations or anyone acting on behalf of the organization to inform members and potential members of the plan as to the coverage offered by the plan and the operation of the organization shall not be a violation of any provisions of law relating to solicitation of customers or advertising by prepaid dental plan providers, if the advertising or sales material:

1. is approved prior to use, by the Commissioner upon determination by the Commissioner that the advertising or sales material is not inaccurate, false, deceptive, or misleading; and

2. does not identify the providers of dental services nor describe their professional qualifications, except upon the request of the member or potential member; and

3. does not describe the professional experience or attainments of providers of dental services individually or as a group, or contain language that states, evaluates or lauds the professional competence, skills or reputations of such providers; and

4. shall not cause any providers of dental services to violate any professional ethics or laws prohibiting the solicitation of patients.

Added by Laws 1983, c. 66, § 16, eff. Nov. 1, 1983.

§36-6157. Rules and regulations.

The Commissioner may adopt any rules and regulations necessary for the implementation and administration of the provisions of the Prepaid Dental Plan Act.

Added by Laws 1983, c. 66, § 17, eff. Nov. 1, 1983.

§36-6201. Short Title.

This act may be cited as the "Insurance Adjusters Licensing Act."

Laws 1973, c. 178, § 1.

§36-6202. Definitions.

As used in the Insurance Adjusters Licensing Act:

1. "Commissioner" means the Insurance Commissioner of the state or his or her lawfully authorized representative;

2. "Adjuster" means either an insurance adjuster or a public adjuster;

3. "Insurance adjuster" means any person, firm, association, company, or legal entity that acts in this state for an insurer, and

that investigates claims, adjusts losses, negotiates claim settlements, or performs incidental duties arising pursuant to the provisions of insurance contracts on behalf of an insurer and includes:

- a. "independent adjusters", meaning any insurance adjuster that suggests or presents to the insurance industry and public that said adjuster acts as an adjuster for a fee or other compensation, and
- b. "company or staff adjusters", meaning adjusters who engage in the investigation, adjustment, and negotiation of claims as salaried employees of an insurer;

4. "Public adjuster" means any person, firm, association, company, or corporation that suggests or presents to members of the public that said public adjuster represents the interests of an insured or third party for a fee or compensation. Public adjusters may investigate claims and negotiate losses to property only;

5. "Insurer" means any authorized insurance company, corporation, reciprocal group, mutual group, underwriting association or bureau, or any combination thereof, writing or underwriting any insurance contracts;

6. "Home state" means the District of Columbia and any state or territory of the United States in which the adjuster's principal place of residence or principal place of business is located. If neither the state in which the adjuster maintains the principal place of residence nor the state in which the adjuster maintains the principal place of business has a licensing or examination requirement, the adjuster may declare another state which has an examination requirement and in which the adjuster is licensed to be the "home state"; and

7. "Automated claims adjudication system" means a preprogrammed computer system designed for the collection, data entry, calculation and final resolution of consumer electronic products insurance claims which:

- a. may only be utilized by a licensed independent adjuster, licensed agent, or individuals supervised by a licensed independent adjuster or licensed agent,
- b. shall comply with all claims payment requirements of the Oklahoma Insurance Code, and
- c. shall be certified as compliant by a licensed independent adjuster.

Added by Laws 1973, c. 178, § 2. Amended by Laws 1983, c. 129, § 1, eff. Nov. 1, 1983; Laws 1997, c. 418, § 113, eff. Nov. 1, 1997; Laws 2007, c. 125, § 23, eff. July 1, 2007; Laws 2011, c. 278, § 30, eff. Nov. 1, 2011.

§36-6203. Persons not deemed adjusters or required to obtain license.

The definition of an insurance adjuster shall not be deemed to include, and a license as an insurance adjuster shall not be required of, the following:

1. A licensed agent or general agent of an insurer who processes undisputed or uncontested losses for the 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;

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

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;

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

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;

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;

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;

8. A nonresident insurance adjuster who is actively licensed in another state and who is in this state no more than once a year for the purpose of adjusting a single loss or who is acting as a temporary substitute for a licensed adjuster; or

9. An individual who collects claim information from, or furnishes claim information to, insured customers or claimants, and who conducts data entry including entering data into an automated claims adjudication system, provided that the individual is an employee of a licensed independent adjuster or an affiliate where no more than twenty-five persons are under the supervision of one licensed independent adjuster or licensed agent. A licensed agent acting as a supervisor pursuant to this paragraph is not required to be licensed as an adjuster.

Added by Laws 1973, c. 178, § 3. Amended by Laws 1983, c. 129, § 2, eff. Nov. 1, 1983; Laws 2009, c. 176, § 40, eff. Nov. 1, 2009; Laws 2011, c. 278, § 31, eff. Nov. 1, 2011; Laws 2019, c. 294, § 8, eff. Nov. 1, 2019.

§36-6204. Repealed by Laws 2009, c. 176, § 60, eff. Nov. 1, 2009.

§36-6204.1. Apprentice adjuster license - Application - Terms and conditions.

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.

Added by Laws 2009, c. 176, § 41, eff. Nov. 1, 2009.

§36-6205. Application for license - Nonresidents.

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 or in another state in which the applicant is currently licensed and in good standing;

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 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.

D. An individual who is a resident of Canada shall not be licensed pursuant to the Insurance Adjusters Licensing Act nor designate this state as the individual's home state, unless the individual has successfully passed the adjuster examination and has complied with all applicable requirements of the Insurance Adjusters Licensing Act; except that any such applicant shall not be required to comply with paragraph 2 of subsection A of Section 6206 of this title or Section 6215 of this title.

Added by Laws 1973, c. 178, § 5. Amended by Laws 1983, c. 129, § 4, eff. Nov. 1, 1983; Laws 1996, c. 246, § 13, eff. July 1, 1996; Laws 2007, c. 125, § 24, eff. July 1, 2007; Laws 2009, c. 176, § 42, eff. Nov. 1, 2009; Laws 2011, c. 278, § 32, eff. Nov. 1, 2011; Laws 2015, c. 297, § 1, eff. Nov. 1, 2015.

§36-6206. Evidence to be furnished for license - Certain personal information exempt from disclosure as public records - Mailing addresses.

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 within two (2) years prior to date of application, 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 legal name or preferred mailing address, physical business address, e-mail address, or physical residential 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.

D. An adjuster doing business in this state under any name other than the adjuster's legal name shall notify the Insurance Commissioner and submit any payment necessary electronically and in the form and manner prescribed by the Commissioner prior to using the assumed name.

Added by Laws 1973, c. 178, § 6. Amended by Laws 1983, c. 129, § 5, eff. Nov. 1, 1983; Laws 1992, c. 261, § 3, eff. Sept. 1, 1992; Laws 1996, c. 246, § 14, eff. July 1, 1996; Laws 2007, c. 125, § 25, eff. July 1, 2007; Laws 2009, c. 176, § 43, eff. Nov. 1, 2009; Laws 2012, c. 44, § 13, eff. Nov. 1, 2012; Laws 2019, c. 294, § 9, eff. Nov. 1, 2019; Laws 2023, c. 196, § 3, eff. Nov. 1, 2023.

§36-6207. Insurance adjuster or public adjuster.

A. The Commissioner may issue a license to an insurance adjuster or a public adjuster in accordance with the provisions of the Insurance Adjusters Licensing Act.

B. A firm, association, company, or corporation shall be licensed only as an adjuster. In the case of a firm each general partner and each other individual to act for the firm pursuant to the license, and in the case of a corporation, association, or company each individual to act for the corporation, association, or company pursuant to the license, shall be named in the license and shall qualify therefor as though an individual licensee. The Commissioner shall charge a full license fee for each firm, association, company, or corporation and a full additional license fee for each individual acting for the firm, association, company, or corporation.

Amended by Laws 1983, c. 129, § 6, eff. Nov. 1, 1983.

§36-6208. Examination - Exemptions.

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 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 twelve-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.

Added by Laws 1973, c. 178, § 8. Amended by Laws 1981, c. 230, § 5, emerg. eff. June 22, 1981; Laws 1983, c. 129, § 7, eff. Nov. 1, 1983; Laws 1985, c. 258, § 7, eff. Nov. 1, 1985; Laws 2007, c. 125, § 26, eff. July 1, 2007; Laws 2009, c. 176, § 44, eff. Nov. 1, 2009; Laws 2011, c. 242, § 7 and Laws 2011, c. 293, § 7, eff. June 20, 2011.

NOTE: Laws 2011, c. 242, § 7 and Laws 2011, c. 293, § 7 made identical changes to this section.

§36-6209. Scope of examination - Classes of insurance - Study manual.

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. Property, including but not limited to marine, inland marine, aircraft and 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. Casualty, meaning all lines of liability insurance coverages for bodily injuries, personal injury, and property damages; or

3. Workers' compensation; or

4. Crime and fidelity bonds; or

5. Crop/hail; or

6. Multi-peril crop.

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 Forty Dollars (\$40.00) for the study manual.

Added by Laws 1973, c. 178, § 9. Amended by Laws 1983, c. 129, § 8, eff. Nov. 1, 1983; Laws 2009, c. 176, § 45, eff. Nov. 1, 2009; Laws 2011, c. 242, § 8 and Laws 2011, c. 293, § 8, eff. June 20, 2011.

NOTE: Laws 2011, c. 242, § 8 and Laws 2011, c. 293, § 8 made identical changes to this section.

§36-6210. Supervision of examination - Time and place - Waiting period.

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. 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 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 examination. Examination fees for subsequent examinations shall not be waived.

Added by Laws 1973, c. 178, § 10. Amended by Laws 1983, c. 129, § 9, eff. Nov. 1, 1983; Laws 1996, c. 246, § 15, eff. July 1, 1996; Laws 2007, c. 125, § 27, eff. July 1, 2007; Laws 2008, c. 184, § 24, eff. July 1, 2008; Laws 2009, c. 176, § 46, eff. Nov. 1, 2009; Laws 2011, c. 242, § 9 and Laws 2011, c. 293, § 9, eff. June 20, 2011.

NOTE: Laws 2011, c. 242, § 9 and Laws 2011, c. 293, § 9 made identical changes to this section.

§36-6211. Form of license - Contents.

The license of an adjuster shall be in a form prescribed by the Insurance Commissioner. The license shall contain:

1. The name and mailing address of the adjuster;

2. Indication as to whether the adjuster is licensed as an insurance adjuster or as a public adjuster;

3. The date of issuance and the date of expiration of the license;

4. The classes of business the license is to cover; and

5. Other information which the Commissioner deems necessary.

Added by Laws 1973, c. 178, § 11. Amended by Laws 1983, c. 129, § 10, eff. Nov. 1, 1983; Laws 1996, c. 246, § 16, eff. July 1, 1996.

§36-6212. Fees - Notification of change of name, address, or e-mail address.

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 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);
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 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. The affidavit shall be in a form prescribed by the Commissioner. The fee for a duplicate license shall be one-half (1/2) the fee of the license.

F. Licensees shall inform by any means acceptable to the Commissioner of a change of legal name, address or e-mail address

within thirty (30) days of the change to permit the Commissioner to give proper notice to licensees. A change in legal name or address submitted more than thirty (30) days after the change shall include an administrative fee of Fifty Dollars (\$50.00). Failure to provide acceptable notification of a change of legal name or address to the Commissioner within forty-five (45) days of the date the administrative fee is assessed shall result in penalties pursuant to subsection B of Section 6220 of this title.

Added by Laws 1973, c. 178, § 12. Amended by Laws 1981, c. 230, § 6, emerg. eff. June 22, 1981; Laws 1983, c. 129, § 11, eff. Nov. 1, 1983; Laws 1985, c. 258, § 8, eff. Nov. 1, 1985; Laws 1996, c. 246, § 17, eff. July 1, 1996; Laws 2000, c. 353, § 45, eff. Nov. 1, 2000; Laws 2009, c. 176, § 47, eff. Nov. 1, 2009; Laws 2011, c. 278, § 33, eff. Nov. 1, 2011.

§36-6213. Repealed by Laws 2009, c. 432, § 27, eff. July 1, 2009.

§36-6214. Bond of public adjuster.

A. Prior to the issuance of a license as a public adjuster or any renewal of the license, the applicant shall file with the Commissioner a surety bond in favor of the people of the State of Oklahoma, executed by a surety company authorized to do business in the state, in the amount of Twenty-five Thousand Dollars (\$25,000.00). The total aggregate liability on the bond may be limited to the payment of Twenty-five Thousand Dollars (\$25,000.00). The bond shall be conditioned on the accounting by the adjuster to any insured whose claim the adjuster is handling for monies or any other settlement received in connection with the claim.

B. Any bond shall remain in force concurrently with the license or until the surety is released from liability by the Commissioner, or until canceled by the surety. Without prejudice to any liability accrued prior to the cancellation, the surety may cancel a bond upon thirty (30) days' advance notice in writing filed with the Commissioner.

C. Effective December 1, 1983, such bond shall be required of all public adjusters.

Added by Laws 1973, c. 178, § 14. Amended by Laws 1983, c. 129, § 13, eff. Nov. 1, 1983; Laws 2015, c. 297, § 2, eff. Nov. 1, 2015.

§36-6215. Place of business.

Every licensed adjuster residing in this state shall have and maintain in this state a place of business accessible to the public. Said place of business shall be located where the adjuster principally conducts transactions in accordance with his or her license.

Added by Laws 1973, c. 178, § 15. Amended by Laws 1983, c. 129, § 14, eff. Nov. 1, 1983; Laws 1996, c. 246, § 18, eff. July 1, 1996; Laws 2007, c. 125, § 28, eff. July 1, 2007.

§36-6216. Powers of adjuster; Current license required for claim referral.

A. An adjuster shall have authority in accordance with his license only to investigate or report to his principal upon claims on behalf of insurers if the adjuster is licensed as an insurance adjuster, or on behalf of insured if licensed as a public adjuster. This limitation of powers shall not prohibit the insurer or insured from granting additional powers to the adjuster.

B. An insurer shall not knowingly refer any claim of loss for adjustment in this state to any person purporting to be or acting as an adjuster unless such a person is currently licensed as an adjuster as required by the provisions of the Insurance Adjusters Licensing Act.

C. Prior to referring any claim of loss to an adjuster, the insurer shall ascertain whether or not the adjuster is currently licensed pursuant to the provisions of the Insurance Adjusters Licensing Act. Having once ascertained that an adjuster is licensed, the insurer may assume that the adjuster shall continue to be licensed until the insurer has knowledge or has received information to the contrary.

Amended by Laws 1983, c. 129, § 15, eff. Nov. 1, 1983; Laws 1985, c. 258, § 9, eff. Nov. 1, 1985.

§36-6216.1. Payment of claim to public adjuster - Insured as joint payee.

No insurance company authorized to transact insurance in this state shall make payment of any insurance claim, or any portion of a claim, to a public adjuster on account of services rendered by a public adjuster to an insured unless the name of the insured is added as a joint payee on any claim check, draft or electronic payment. The payment, whether by check, draft, electronic payment or otherwise, shall be sent to the address or electronic mail address designated by the insured.

Added by Laws 1993, c. 248, § 5, eff. Sept. 1, 1993. Amended by Laws 2021, c. 478, § 31, emerg. eff. May 12, 2021.

§36-6216.2. Contract for services of public adjuster - Cancellation.

A. The insured has the right to cancel any compensation agreement entered into with a licensed public adjuster until midnight of the third business day after the day on which the signed agreement was provided to the insured.

B. Cancellation occurs when the insured gives written notice of cancellation to the licensed public adjuster at the address stated in the agreement between the parties. Notice of cancellation may be given by mail and is given when deposited in a United States mailbox properly addressed and postage prepaid. Notice of cancellation must contain the written intention of the insured to cancel the agreement. No liability accrues to the insured when the agreement is canceled within said period, except for reasonable expense incurred by the public adjuster in preserving the damaged premises during the said three-day period. Anything of value given by the insured under the contract shall be returned to the insured within fifteen (15) business days following the receipt by the public adjuster of the cancellation notice.

C. Every contract for services to be rendered by a public adjuster shall contain the following statement. It shall be in boldface ten-point or larger type and located conspicuously on the front face of the contract. "THIS CONTRACT MAY BE CANCELED WITHIN THREE (3) DAYS AFTER THE INSURED PARTY HAS RECEIVED AN ORIGINAL SIGNED COPY OF THIS AGREEMENT".

D. Every contract for services to be rendered by a public adjuster shall be in writing and contain the following information:

1. Legible full name of the public adjuster signing the contract, as specified in Insurance Department records;
2. Permanent home state business address and phone number;
3. Department license number;
4. Title of "Public Adjuster Contract";
5. The insured's full name, street address, insurance company name and policy number, if known or upon notification;
6. A description of the loss and its location, if applicable;
7. Description of services to be provided to the insured;
8. Signatures of the public adjuster and the insured;
9. Date contract was signed by the public adjuster and date the contract was signed by the insured; and
10. Full salary, fee, commission, compensation or other considerations the public adjuster is to receive for services pursuant to the following guidelines:
 - a. if the compensation is based on a share of the insurance settlement, the exact percentage shall be specified,
 - b. initial expenses to be reimbursed to the public adjuster from the proceeds of the claim payment shall be specified by type, with dollar estimates set forth in the contract and with any additional expenses first approved by the insured,
 - c. compensation provisions in a public adjusting contract shall not be redacted in any copy of a contract provided to the Department upon request. Such a

redaction shall constitute an omission of material fact, and

- d. the public adjuster and the insured shall both indicate their agreement to the compensation provision(s) of the contract by initialing next to the provision(s) in the contract.

E. If the insurer, not later than seventy-two (72) hours after the date on which the loss is reported to the insurer, either pays or commits in writing to pay to the insured a policy coverage limit(s), the public adjuster shall, with respect to that coverage:

1. Not receive a commission consisting of a percentage of the total amount paid by an insurer to resolve a claim;
2. Inform the insured that loss recovery amount might not be increased by insurer; and
3. Be entitled only to reasonable compensation from the insured for services provided by the public adjuster on behalf of the insured, based on the time spent on a claim and expenses incurred by the public adjuster, until the claim is paid or the insured receives a written commitment to pay from the insurer.

F. A public adjuster contract may not contain any contract term that:

1. Allows the public adjuster's percentage fee to be collected when money is due from an insurance company but not paid, or that allows a public adjuster to collect the entire fee from the first check issued by an insurance company, rather than as a percentage of each check issued by an insurance company;
2. Requires the insured to authorize an insurance company to issue a check only in the name of the public adjuster;
3. Imposes collection costs or late fees; or
4. Precludes any party from pursuing civil remedies.

G. At the time of signing, a public adjuster shall deliver to the insured, in any manner acceptable to the insured and approved by the Insurance Commissioner, a copy of the original executed contract.

H. A public adjuster contract may specify that the public adjuster shall be named as a joint payee on an insurer's payment of a claim.

I. The Insurance Commissioner reserves the right to approve forms of contracts containing language other than that specified in this section if:

1. Such language reasonably discloses to the insured the statutory rights under this section and is otherwise consistent with all other provisions of law and regulations promulgated; or
2. The Commissioner finds that the requirements of this section are, in the Commissioner's opinion, unnecessary due to the nature and scope of the business of the insured party to which the contract will apply.

Added by Laws 1993, c. 248, § 6, eff. Sept. 1, 1993. Amended by Laws 2015, c. 297, § 3, eff. Nov. 1, 2015.

§36-6217. Term of license - Continuing education - Rules - Renewals of license - Provider fee.

A. 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 twenty-four (24) clock hours of continuing insurance education, of which three (3) hours shall be in ethics, within the previous twenty-four (24) months prior to renewal of the license. 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;
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-four (24) hours. Each approved professional designation program included in this section shall be reviewed for quality and compliance every two (2) 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 two (2) 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. 1. 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 Section 307.3 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.

2. The Commissioner may assess a civil penalty, after notice and opportunity for hearing, against a continuing education provider who fails to comply with the requirements of the Insurance Adjusters Licensing Act, of not more than Five Hundred Dollars (\$500.00), for each occurrence. The civil penalty may be enforced in the same manner in which civil judgments may be enforced.

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.

Added by Laws 1973, c. 178, § 17. Amended by Laws 1983, c. 129, § 16, eff. Nov. 1, 1983; Laws 1985, c. 258, § 10, eff. Nov. 1, 1985; Laws 1994, c. 376, § 1; Laws 1995, c. 164, § 1, eff. Nov. 1, 1995; Laws 2000, c. 353, § 46, eff. Nov. 1, 2000; Laws 2001, c. 33, § 34, eff. July 1, 2001; Laws 2007, c. 125, § 29, eff. July 1, 2007; Laws 2008, c. 184, § 25, eff. July 1, 2008; Laws 2009, c. 176, § 48, eff. Nov. 1, 2009; Laws 2010, c. 355, § 2, eff. Nov. 1, 2010; Laws 2011, c. 278, § 34, eff. Nov. 1, 2011; Laws 2012, c. 11, § 10, emerg. eff. April 4, 2012; Laws 2012, c. 44, § 14, eff. Nov. 1, 2012; Laws 2013, c. 269, § 14, eff. Nov. 1, 2013; Laws 2021, c. 478, § 32, emerg. eff. May 12, 2021; Laws 2023, c. 196, § 4, eff. Nov. 1, 2023.

NOTE: Laws 2011, c. 242, § 10 repealed by Laws 2012, c. 11, § 11, emerg. eff. April 4, 2012. Laws 2011, c. 293, § 10 repealed by Laws 2012, c. 11, § 12, emerg. eff. April 4, 2012.

§36-6218. Catastrophes.

A. In the event of a catastrophe, the Insurance Commission may declare an emergency to exist, and in the event of such a declaration, the Commissioner may issue a license as an emergency adjuster to any resident or nonresident applicant. Such declaration of emergency may be made per zip code or on a county-by-county basis, or any combination thereof. An individual licensed as an emergency adjuster pursuant to this section may only adjust claims related to the catastrophe. The applicant shall not have to be a licensed adjuster. An applicant for this license shall be certified in the manner prescribed by the Commissioner by an adjuster licensed in this state or by an insurer who maintains an office in this state and is licensed to do business in this state. A licensed adjuster or insurer who certifies an applicant for this license shall be responsible for any losses caused by the applicant or for any improper claim handling practices committed by the applicant. The employer of this applicant shall certify the application for license as an emergency adjuster to the Commissioner within five (5) days after the applicant begins working as an emergency adjuster for the employer. The license as an emergency adjuster shall remain in force for not more than ninety (90) days from the date the Commissioner issues an emergency declaration order. The emergency declaration order may be extended an additional ninety (90) days at the Commissioner's discretion. An emergency adjuster may only adjust claims resulting from the particular catastrophe for which the emergency declaration order is issued.

B. The Commissioner may suspend or revoke the right of any person acting as an adjuster or an emergency adjuster in this state pursuant to the authority derived from the provisions of the Insurance Adjusters Licensing Act to continue to adjust claims in this state after a hearing on the suspension or revocation if the Commissioner finds that said person has engaged in any of the practices forbidden to a licensed adjuster. Notice of the hearing on said suspension or revocation shall be given personally or shall be sent by mail to the address stated in the registration. A duplicate copy of the notice shall be given to the insurer.

C. No public adjuster shall charge, agree to or accept as compensation or reimbursement any payment, commission, fee or other thing of value equal to more than ten percent (10%) of the amount of the insurance settlement claim paid by the insurer on any claim resulting from a catastrophe declared by the Commissioner to be an emergency pursuant to subsection A of this section. The provisions of this subsection shall not apply to a public adjuster providing public adjuster services on behalf of a for-profit commercial entity.

Added by Laws 1973, c. 178, § 18. Amended by Laws 1983, c. 129, § 17, eff. Nov. 1, 1983; Laws 1997, c. 418, § 114, eff. Nov. 1, 1997; Laws 2015, c. 297, § 4, eff. Nov. 1, 2015.

§36-6219. Initial license; grounds for refusal.

The Commissioner may refuse to issue an initial license for any of the causes set out in Section 6220 of this title, failure to pass the required examination, or prior revocation of an adjuster's license in this state or in any other state.

Amended by Laws 1983, c. 129, § 18, eff. Nov. 1, 1983.

§36-6220. Suspension, revocation or refusal to renew license - Grounds - Civil penalties - Surrender of license - Reinstatement.

A. The Commissioner may censure, suspend, revoke, or refuse to issue or renew a license pursuant to the Insurance Adjusters Licensing Act, levy a civil penalty in accordance with subsection B of this section, or any combination of actions for any of the following causes:

1. Material misrepresentation or fraud in obtaining an adjuster's license;
2. Any cause for which original issuance of a license could have been refused;
3. Misappropriation, conversion to the personal use of the licensee, or illegal withholding of monies required to be held by the licensee in a fiduciary capacity;
4. Material misrepresentation of the terms and effect of any insurance contract, with intent to deceive, or engaging in, or attempting to engage in, any fraudulent transaction with respect to

a claim or loss that the licensee or the trainee is adjusting and, in the case of a public adjuster, misrepresentation of the services offered or the fees or commission to be charged;

5. Conviction of or pleading guilty or nolo contendere to a felony pursuant to the laws of this state, any other state, the United States, or any foreign country;

6. If in the conduct of business affairs, the licensee or trainee has shown himself to be, and is so deemed by the Commissioner, incompetent, untrustworthy or a source of injury to the public;

7. Refusal to comply with any lawful order of the Commissioner;

8. Violation of any provision of the Insurance Adjusters Licensing Act;

9. Adjusting losses or negotiating claim settlements arising pursuant to provisions of insurance contracts on behalf of an insurer or insured without proper licensing from the Commissioner and authority from the licensed insurer or the insured party;

10. Failing to respond to any inquiry (including electronic communications) from the Department within thirty (30) calendar days of receipt of such inquiry;

11. Forging another's name to any document;

12. Improperly using notes or any other reference material to complete an examination for an insurance license;

13. Having admitted or been found to have committed any insurance unfair trade practice or insurance fraud;

14. Having an insurance adjuster license or its equivalent denied, suspended, censured, placed on probation or revoked in any other state, province, district or territory;

15. Failing to inform the Department, by any means acceptable to the Department, of a change of address, change of legal name or change of information submitted on the application within thirty (30) days of the change; or

16. Providing services as a public adjuster, company adjuster or independent adjuster on the same claim.

B. In addition to or in lieu of any applicable denial, suspension, or revocation of a license, any person violating the provisions of the Insurance Adjusters Licensing Act may be subject to a civil fine of not more than One Thousand Dollars (\$1,000.00) for each violation. This fine may be enforced in the same manner in which civil judgment may be enforced.

C. The Commissioner shall not reinstate a license to any person whose license has been suspended, revoked, or refused renewal until the Commissioner determines that the cause or causes for the suspension, revocation, or nonrenewal of the license no longer exist.

D. The Department shall retain the authority to enforce the provisions of and impose any penalty or remedy authorized by this

title against any person who is under investigation for or charged with a violation even if the person's license or registration has been surrendered or has lapsed by operation of law.

E. It shall be unlawful for any person, firm, association, company or corporation to act as an adjuster without first obtaining a license pursuant to the Insurance Adjusters Licensing Act. Any person convicted of violating the provisions of this subsection shall be guilty of a misdemeanor and shall be punished as set forth in Section 10 of Title 21 of the Oklahoma Statutes. The restriction set forth in this subsection shall apply regardless of whether the person, firm, association, company or corporation has obtained power of attorney from an insurance claimant or has entered into any other agreement with an insurance claimant to act on the behalf of the claimant.

Added by Laws 1973, c. 178, § 20. Amended by Laws 1983, c. 129, § 19, eff. Nov. 1, 1983; Laws 2015, c. 297, § 5, eff. Nov. 1, 2015; Laws 2016, c. 73, § 10, eff. Nov. 1, 2016; Laws 2019, c. 294, § 10, eff. Nov. 1, 2019; Laws 2023, c. 196, § 5, eff. Nov. 1, 2023.

§36-6220.1. Prohibition on pecuniary interest in construction businesses - Penalties - Exceptions.

A. No adjuster may, directly or indirectly, own or have a pecuniary interest in any business entity which provides construction or reconstruction related services on behalf of an insurance claimant or insured for which the adjuster is providing services, nor may the adjuster, directly or indirectly, own or have a pecuniary interest in any other business entity which furnishes any supplies, material, services, or equipment purchased by or on behalf of the claimant or insured in settlement of the claim, other than usual and customary supplies, materials, services, or equipment utilized in the adjusting process.

B. Any person who violates the provisions of this section shall be subject to disciplinary action or a civil fine, or both, as set forth in Section 6220 of this title.

C. This section shall not apply to an adjuster providing services on a claim which is located in a municipality having a population of less than six thousand (6,000) persons; provided, however, the adjuster shall give written disclosure of the potential conflict of interest to both the insured and insurer prior to the performance of any adjuster services.

D. The restrictions set forth in subsection A of this section shall apply regardless of whether the person or entity has obtained power of attorney from an insurance claimant or has entered into any other agreement with an insurance claimant to act on the behalf of the claimant.

Added by Laws 1995, c. 243, § 1, eff. Nov. 1, 1995. Amended by Laws 2015, c. 297, § 6, eff. Nov. 1, 2015; Laws 2019, c. 294, § 11, eff. Nov. 1, 2019.

§36-6221. Repealed by Laws 2021, c. 478, § 42, emerg. eff. May 12, 2021.

§36-6222. Report of administration actions against adjusters.

A. An adjuster shall report to the Insurance Commissioner any administrative action taken against the adjuster in another jurisdiction or by another governmental agency in this state within thirty (30) days of the final disposition of the matter. This report shall include a copy of the order, consent to order or other relevant legal documents.

B. Within thirty (30) days of the initial pretrial hearing date, an adjuster shall report to the Insurance Commissioner any criminal prosecution of the adjuster taken in any jurisdiction. The report shall include a copy of the initial complaint filed, the order resulting from the hearing and any other relevant legal documents.

Added by Laws 2012, c. 44, § 15, eff. Nov. 1, 2012.

§36-6223. Public adjuster responsibilities.

A. A public adjuster shall not misrepresent to a claimant that the public adjuster is an adjuster representing an insurer in any capacity, including acting as an employee of the insurer or acting as an independent adjuster.

B. No public adjuster shall split any commission, service fee or other valuable consideration for performing adjusting services with any person or entity unless that person or entity is required to be licensed as a public adjuster under this title and is so licensed.

C. Prior to the signing of the contract the public adjuster shall provide the insured with a separate disclosure document regarding the claim process that states:

1. Property insurance policies obligate the insured to present a claim to his or her insurance company for consideration. There are three types of adjusters that could be involved in that process. The definitions of the three types are as follows:

- a. "company adjuster" means the insurance adjusters who are employees of an insurance company. They represent the interest of the insurance company and are paid by the insurance company. They will not charge you a fee,
- b. "independent adjuster" means the insurance adjusters who are hired on a contract basis by an insurance company to represent the insurance company's interest

in the settlement of the claim. They are paid by your insurance company. They will not charge you a fee, and

- c. "public adjuster" means the insurance adjusters who do not work for any insurance company. They work for the insured to assist in the preparation, presentation and settlement of the claim. The insured hires them by signing a contract agreeing to pay them a fee or commission based on a percentage of the settlement, or other method of compensation;

2. The insured is not required to hire a public adjuster to help the insured meet his or her obligations under the policy, but has the right to do so;

3. The public adjuster is not a representative or employee of the insurer; and

4. The salary, fee, commission or other consideration is the obligation of the insured, not the insurer.

D. The public adjuster shall provide the insurer a notification letter which has been signed by the insured authorizing the public adjuster to represent the insured's interest.

E. A public adjuster who receives, accepts or holds any funds on behalf of an insured towards the settlement of a claim for loss or damage shall deposit the funds in a non-interest-bearing escrow or trust account in a financial institution that is insured by an agency of the federal government in the public adjuster's home state or where the loss occurred.

F. A public adjuster shall maintain a complete record of each transaction as a public adjuster for at least five (5) years after the termination of the transaction and the record shall be open to examination by the Department at all times. The records required by this subsection shall include the following:

1. Name of the insured;

2. Date, location and amount of the loss;

3. Copy of the signed contract between the public adjuster and insured;

4. Name of the insurer, amount, expiration date and number of each policy carried with respect to the loss;

5. Itemized statement of the insured's recoveries;

6. Itemized statement of all compensation received by the public adjuster, from any source whatsoever, in connection with the loss;

7. A register of all monies received, deposited, disbursed or withdrawn in connection with a transaction with an insured, including fees, transfers and disbursements from a trust account, and all transactions concerning all interest-bearing accounts;

8. Name of the public adjuster who executed the contract; and

9. Name of the attorney representing the insured, if applicable, and the name of the claims representatives of the insurance company.

G. A public adjuster is obligated under his or her license to serve with objectivity and complete loyalty to the interest of his or her client alone; and to render to the insured such information, counsel and service as within the knowledge, understanding and opinion in good faith of the licensee will best serve the insured's insurance claim needs and interest.

H. A public adjuster shall not solicit or attempt to solicit an insured during the progress of a loss-producing occurrence.

I. A public adjuster shall not permit an unlicensed employee or representative of the public adjuster to conduct business for which a license is required.

J. A public adjuster shall not acquire any interest in salvage of property subject to the contract with the insured unless the public adjuster obtains written permission from the insured after settlement of the claim with the insurer.

K. The public adjuster shall not refer or direct the insured to obtain needed repairs or services in connection with a loss from any person or entity with whom the public adjuster has a financial interest or from whom the public adjuster may receive direct or indirect compensation for the referral.

L. Any compensation or anything of value in connection with an insured's specific loss that will be received by a public adjuster from any third party shall be disclosed by the public adjuster to the insured in writing including the source and amount of any such compensation.

M. A public adjuster shall not enter into a contract or accept a power of attorney that vests in the public adjuster the effective authority to choose the persons who shall perform repair work.

N. A public adjuster may not agree to any loss settlement without the insured's knowledge and consent.

O. On a percentage fee contract, a public adjuster may not require, demand or accept any fee, retainer, compensation, deposit or other thing of value prior to payment of any claim proceeds, whether such payment is partial in nature or payment in full. Added by Laws 2015, c. 297, § 7, eff. Nov. 1, 2015. Amended by Laws 2016, c. 73, § 11, eff. Nov. 1, 2016.

§36-6301. Short title.

This act shall be known and may be cited as the "Arson and Theft Reporting Immunity Act".

Laws 1979, c. 147, § 1; Laws 1993, c. 223, § 1, eff. Sept. 1, 1993.

§36-6302. Definitions.

As used in this act:

1. Authorized agencies include:
 - a. the State Fire Marshal and the marshal or head of any county or local fire or theft investigatory agency,
 - b. the Director of the State Bureau of Investigation,
 - c. the district attorney in the county where the fire or theft occurred, and
 - d. for the purposes of subsection A of Section 6303 of this title, the Federal Bureau of Investigation, the United States Attorney or any other federal agency authorized or charged with investigation or prosecution with respect to a fire or theft;

2. Relevant information means any information having a tendency to make the existence of any fact that is of consequence to the investigation or determination of the issue more probable or less probable than it would be without the information; and

3. Action includes the failure to take action.

Added by Laws 1979, c. 147, § 2. Amended by Laws 1993, c. 223, § 2, eff. Sept. 1, 1993; Laws 1999, c. 333, § 5, eff. July 1, 1999.

§36-6303. Release of relevant information - Information included.

A. Any authorized agency may by written request require an insurance company to release to the authorized agency any relevant information or evidence which the company may have in its possession, relating to a fire or theft loss under investigation by such agency. Relevant information includes, but is not limited to:

1. Information with regard to the policy covering a fire or theft loss under investigation and any application for such policy;
2. Records of policy premium payments;
3. The limits of coverage under the policy;
4. History of previous claims made by the insured; and
5. Any material or evidence relating to the investigation of the loss, including statements of any person or proof of loss.

B. When an insurance company has reason to believe that a fire loss in which it has an interest may be of other than accidental cause, the company shall in writing notify an authorized agency and provide it with all information, documents and evidence relating to the company's inquiry into the fire loss, for the purpose of having such fire loss investigated.

C. An authorized agency provided with information pursuant to subsections A or B of this section may release or provide such information to any other authorized agency.

D. Any insurance company providing information to an authorized agency pursuant to this act shall have the right to request from the authorized agency additional information relating to the fire or theft loss. The authorized agency may release the requested information, but the release of the information is not mandatory. Provided that the insured shall be notified of any information

provided pursuant to this act. Such notice shall include the name and address of the entity to whom information is provided, as well as copies of all information so provided if such copies are requested by the insured.

Laws 1979, c. 147, § 3; Laws 1993, c. 223, § 3, eff. Sept. 1, 1993.

§36-6304. Immunity.

Any insurance company or person acting in its behalf, or any authorized agency who, in good faith and without actual malice toward the insured, releases oral or written information pursuant to this act shall be immune from any liability arising out of a civil action or penalty resulting from a criminal prosecution with respect to the release of such information.

Laws 1979, c. 147, § 4.

§36-6305. Confidentiality of information - Witnesses.

A. Any authorized agency or insurance company who receives any information furnished pursuant to this act shall hold the information in confidence until such time as its release is required by law, or required pursuant to a criminal or civil proceeding.

B. The agents or employees of any authorized agency who have participated in the investigation of a fire loss may be required to testify in any litigation with respect to such fire loss in which an insurance company is named as a party.

Laws 1979, c. 147, § 5.

§36-6306. Violations - Penalties.

Any insurer who intentionally or knowingly refuses to release, provide or hold in confidence any information required by this act to be released, provided, or held in confidence is guilty of a misdemeanor, and upon conviction shall be punished by a fine not to exceed One Thousand Dollars (\$1,000.00).

Laws 1979, c. 147, § 6.

§36-6401. Insurance coverage to be provided for certain persons.

As a condition of doing business in the State of Oklahoma, any insurer duly licensed in Oklahoma and who, on the effective date of this act, is writing custom harvesting insurance in any state in the United States or who has written such insurance in the State of Oklahoma within the past three (3) years shall provide such insurance to those custom harvesters who are unable to procure such insurance in the open or excess insurance market.

Added by Laws 1986, c. 181, § 1, emerg. eff. May 15, 1986.

§36-6402. Rates.

The rates for such custom harvesting insurance shall be those rates on file with the Insurance Commissioner on May 15, 1986, or if

such rates are not on file and need to be submitted or filed with the Insurance Commissioner.

Added by Laws 1986, c. 181, § 2, emerg. eff. May 15, 1986. Amended by Laws 2005, c. 129, § 16, eff. Nov. 1, 2005.

§36-6403. Violations - Penalties.

Failure of any insurer to comply with Section 6401 et seq. of this title may subject the insurer at the discretion of the Insurance Commissioner, after notice and opportunity for hearing, to penalties of censure, suspension or revocation of certification of authority or a civil penalty of up to Five Thousand Dollars (\$5,000.00) for each occurrence or by both such penalty and censure, suspension or revocation of certificate.

Added by Laws 1986, c. 181, § 3, emerg. eff. May 15, 1986. Amended by Laws 1997, c. 418, § 115, eff. Nov. 1, 1997.

§36-6411. Short title.

Sections 44 through 55 of this act shall constitute a part of the Oklahoma Insurance Code and shall be known and may be cited as the "Market Assistance Association Act".

Added by Laws 1986, c. 251, § 44, emerg. eff. June 13, 1986.

§36-6412. Market Assistance Association - Creation.

There is hereby created a Market Assistance Association to assist in the placement of homeowners' and liability insurance coverage for residents of this state.

The Market Assistance Association is not a carrier capable of assuming insurance risks. While it is believed that the Association will be able to solve or at least reduce problems of availability, it has no power to guarantee successful conclusion of all assistance efforts and it is assumed that some risks may not be entitled to coverage.

Added by Laws 1986, c. 251, § 45, emerg. eff. June 13, 1986.

§36-6413. Definitions.

As used in the Market Assistance Association Act:

1. "Association" means the Market Assistance Association established pursuant to this act;
2. "Board" means the Board of Directors of the Market Assistance Association;
3. "Commissioner" means the Insurance Commissioner;
4. "Insurer" means any entity licensed to issue homeowners' or homeowners' liability insurance; and
5. "Member" means all insurers licensed in this state for both property and casualty lines of business. These entities are required to be a participant in the Association as a condition of doing business in Oklahoma.

Added by Laws 1986, c. 251, § 46, emerg. eff. June 13, 1986.
Amended by Laws 2022, c. 358, § 1, eff. Nov. 1, 2022.

§36-6414. Market Assistance Association - Powers and duties - Plan of operation - Insurer's financial liability - Termination of membership.

A. The Association created pursuant to the Market Assistance Association Act shall have the power on behalf of its members to:

1. Require members to issue policies of insurance to applicants, subject to limitations specified in the plan of operation required by the Market Assistance Association Act; irregardless of the type of insurance coverage, the limits of liability for homeowners' liability insurance, shall be governed by the amounts specified in subsection A of Section 154 of Title 51 of the Oklahoma Statutes; and

2. Call upon member insurers who have expertise or familiarity with a particular line of homeowners' liability insurance to assist in underwriting such insurance.

B. The Board after consultation with the Association, the Insurance Commissioner and other affected entities, shall promulgate a plan of operation consistent with the provisions of this section, to become effective no later than ninety (90) days after the date of the inception of the Association.

1. The plan of operation shall provide for economic, fair and nondiscriminatory administration and for prompt and efficient provision of insurance, and shall contain other provisions including, but not limited to, the following:

- a. preliminary assessment of all members for initial expenses necessary to commence operations of the Association,
- b. establishment of necessary facilities,
- c. management of the Association,
- d. assessment of members, and assessment of policyholders if a market assistance association for professionals is declared, to defray losses and expenses,
- e. establishment of committees as may be necessary to facilitate the administration of the Association,
- f. procedures providing that an insured shall have proof that he or she has coverage that has been canceled or nonrenewed by his or her current carrier and has subsequently requested and been refused homeowners' or homeowners' liability coverage from two insurers licensed to do business in this state, or that his or her premium has been increased by seventy-five percent (75%) or more from the previous year, before requesting insurance coverage from the Association,

- g. appointment of members of the Association on a rotating basis to provide homeowners' and homeowners' liability insurance coverage based upon direct premiums for homeowners' and homeowners' liability insurance, written in the state in the preceding calendar year,
- h. procedures for determining amounts of insurance to be provided by members of the Association, and
- i. procedures for two or more member insurers to share an insured risk if coverage for that risk is beyond the ability for one insurer

2. The plan of operation shall provide that any balance remaining in the funds of the Association at the close of its fiscal year shall be added to the reserves of the Association and may be used for expenses of the Association or any successor association.

3. Amendments to the plan of operation may be made by the Board.

C. All insurers who are members of the Association shall participate in the Association's writings, expenses, and losses in the proportion that the net direct premiums of each such member written during the preceding calendar year bears to the aggregate net direct premiums written in this state by all members of the Association. Each insurer's proportion of participation in the Association shall be determined annually on the basis of such net direct premiums written during the preceding calendar year, as reported in the annual statements and other reports filed by the insurer that may be required by the board of directors. No member shall be obligated in any one (1) year to write liability insurance business from the Association that would result in the member insurer writing more than ten percent (10%) of its total annual liability insurance, from all lines of liability insurance, from the Association. Likewise, no member shall be obligated in any one (1) year to write homeowners' insurance business from the Association that would result in the member insurer writing more than ten percent (10%) of its total annual homeowners' insurance, from the Association.

D. An applicable insurer ceasing to be licensed or authorized to transact insurance business pursuant to the Insurance Code shall automatically cease to be a member of the Association effective at 12:01 a.m. on the day following the termination or expiration of its certificate of authority and shall no longer be subject to the plan of operation or requirements of the Association; provided, however, such insurer shall remain liable for any annual assessments of the Association based on expenses incurred by the Association while such license or authority was in effect.

Added by Laws 1986, c. 251, § 47, emerg. eff. June 13, 1986.

Amended by Laws 2022, c. 358, § 2, eff. Nov. 1, 2022.

§36-6415. Board of directors - Membership - Term - Vacancies - Meetings - Approval of selections - Compensation.

A. The business and functions of the Association shall be managed and administered by a Board of eight (8) directors composed of four directors representing Association members, two directors who are representatives of Oklahoma domestic insurers who are Association members, one director who represents a surplus lines carrier who is an Association member, and the Oklahoma Insurance Commissioner or an Oklahoma Insurance Department staff member chosen as a designee by the Oklahoma Insurance Commissioner. Each director shall designate a full-time salaried employee of the insurer to represent the director as an alternate in the absence of the director on the Board. The term of office of each director shall continue until the appointment and qualification of a successor. Any vacancy on the Board shall be filled for the remaining period of the term by the remaining Board directors.

B. The chairman shall call all meetings of the Board and shall give reasonable notice of meetings to all directors. At any meeting of the Board, each Board director or his predesignated alternate shall have one vote. Six members of the Board or their predesignated alternates shall constitute a quorum for the transaction of business and the acts of a majority of the Board members present at a meeting at which a quorum is present shall be the acts of the Board. The Board shall meet as often as may be required to perform the general duties of administration of the Association, but not less frequently than annually.

C. In approving selections to the Board, the Board of Directors shall consider, among other things, whether all Association member insurers are fairly represented.

D. Members of the Board and their predesignated alternates shall serve without compensation but may be reimbursed from the assets of the Association for all actual and necessary expenses incurred by them in performance of their duties for the Board. Added by Laws 1986, c. 251, § 48, emerg. eff. June 13, 1986. Amended by Laws 2022, c. 358, § 3, eff. Nov. 1, 2022.

§36-6416. Good faith statements - Liability.

There shall be no liability on the part of, and no cause of action of any nature shall arise against the Insurance Commissioner or his staff, the Association, its agents or employees, an insurer, any licensed agent, or the board of directors or its authorized representatives for any statements made in good faith by them in any reports or communications, concerning risks insured or to be insured by the Association, or at any administrative hearings conducted in connection therewith.

Added by Laws 1986, c. 251, § 49, emerg. eff. June 13, 1986.

§36-6417. Annual statement - Examination of Accounts, etc. - Report to members.

A. The Association shall submit to the Insurance Commissioner, annually, from the date of its inception, a statement prepared by an independent certified public accountant which shall contain information with respect to its transactions, condition, operations, and affairs during the preceding calendar year. The statement shall contain such matters and information as are prescribed and shall be in such form as is approved by the Commissioner. The Commissioner may, at any time, require the Association to furnish additional information with respect to its transactions, condition, operations, and affairs, or any matter connected therewith considered to be material and of assistance in evaluating the scope, operation and experience of the Association.

B. The books of account, records, reports and other documents of the Association shall be open and free for examination to the Commissioner at all reasonable times.

C. The books of account, records, reports and other documents of the Association shall be open to inspection by the members at such times and under such conditions and regulations as the Board shall determine.

D. The Association shall provide for the making of detailed reports of liability approved or canceled, for the drawing up of annual budgets of the Association and for the rendering of accounts to each Board member at least every twelve (12) months.

Added by Laws 1986, c. 251, § 50, emerg. eff. June 13, 1986.

Amended by Laws 2022, c. 358, § 4, eff. Nov. 1, 2022.

§36-6418. Use of filed rates for liability and homeowners' insurance.

Each member insurer shall use the filed rate for the homeowners' liability and homeowners' insurance being written. Any variance from such rate, including a variance based upon debit, shall be submitted or filed with the Insurance Commissioner.

Added by Laws 1986, c. 251, § 51, emerg. eff. June 13, 1986.

Amended by Laws 2005, c. 129, § 17, eff. Nov. 1, 2005; Laws 2022, c. 358, § 5, eff. Nov. 1, 2022.

NOTE: Editorially renumbered from § 6408 of this title to avoid a duplication in numbering.

§36-6419. Rules and regulations.

The Commissioner may adopt any rules and regulations necessary for the implementation, administration or furtherance of the provisions of the Market Assistance Association Act.

Added by Laws 1986, c. 251, § 52, emerg. eff. June 13, 1986.

§36-6420. Property and casualty insurance companies - Voluntary Market Assistance Association.

Property and casualty insurance companies licensed to transact insurance in the State of Oklahoma are hereby authorized to create and operate a Voluntary Market Assistance Association under the auspices of the Commissioner of Insurance. In the event such Voluntary Association is established and is approved by the Commissioner of Insurance prior to September 11, 1986, then Sections 6411 through 6415, 6417, 6418 and 6421 of the Insurance Code shall not become effective.

Added by Laws 1986, c. 251, § 53, emerg. eff. June 13, 1986. Amended by Laws 1987, c. 175, § 33, eff. Nov. 1, 1987.

§36-6421. Dissolution of Association - Reimplementation.

If at any time after the provisions of this act are implemented, either by voluntary plan or as otherwise provided for herein, the State Insurance Commissioner would determine by written order that there was no further need for such Association, then the same would be dissolved. Provided however, that if such Association were dissolved, and then the State Insurance Commissioner determined at a later time there existed a need for such Association, the Commissioner of Insurance would then proceed according to the provisions of Section 53 of this act, and that section would again be applicable at that time.

If the Commissioner makes such a determination to reimplement the Association, he will give the companies involved ninety (90) days to comply, and if they fail to do so, then Sections 47 through 55 of this act would be applicable.

Added by Laws 1986, c. 251, § 54, emerg. eff. June 13, 1986.

§36-6422. Participation in assessments and writings of Association.

Members of the Market Assistance Association, whether a voluntary or statutory program, shall be required to participate in all assessments and writings of the Association. Failure to participate shall, after notice and opportunity for hearing before the Insurance Commissioner, result in a censure, suspension or revocation of certificate of authority or a civil penalty up to Five Thousand Dollars (\$5,000.00) for each occurrence or by both such penalty and censure, suspension or revocation of certificate of authority.

Added by Laws 1986, c. 251, § 55, emerg. eff. June 13, 1986.

Amended by Laws 1997, c. 418, § 116, eff. Nov. 1, 1997.

§36-6423. Repealed by Laws 1990, c. 236, § 12, eff. July 1, 1991.

§36-6424. Repealed by Laws 1990, c. 236, § 12, eff. July 1, 1991.

§36-6425. Repealed by Laws 1990, c. 236, § 12, eff. July 1, 1991.

§36-6426. Repealed by Laws 1990, c. 236, § 12, eff. July 1, 1991.

§36-6427. Repealed by Laws 1990, c. 236, § 12, eff. July 1, 1991.

§36-6428. Repealed by Laws 1990, c. 236, § 12, eff. July 1, 1991.

§36-6429. Repealed by Laws 1990, c. 236, § 12, eff. July 1, 1991.

§36-6430. Repealed by Laws 1990, c. 236, § 12, eff. July 1, 1991.

§36-6431. Repealed by Laws 1990, c. 236, § 12, eff. July 1, 1991.

§36-6432. Repealed by Laws 1990, c. 236, § 12, eff. July 1, 1991.

§36-6433. Repealed by Laws 1990, c. 236, § 12, eff. July 1, 1991.

§36-6451. Short title.

Sections 1 through 18 of this act shall be a part of the Insurance Code and shall be known as the Oklahoma Risk Retention Act.

Added by Laws 1987, c. 157, § 1, emerg. eff. June 25, 1987.

§36-6452. Operation of act.

The Oklahoma Risk Retention Act shall regulate the formation and operation of risk retention groups in this state formed pursuant to the provisions of the federal Liability Risk Retention Act of 1986.

Added by Laws 1987, c. 157, § 2, emerg. eff. June 25, 1987.

§36-6453. Definitions.

As used in the Oklahoma Risk Retention Act:

1. "Commissioner" means the Insurance Commissioner of this state or the Commissioner, Director, or Superintendent of insurance in any other state;

2. "Completed operations liability" means liability arising out of the installation, maintenance, or repair of any product at a site which is not owned or controlled by:

a. any person who performs that work, or

b. any person who hires an independent contractor to perform that work,

and shall include liability for activities which are completed or abandoned before the date of the occurrence giving rise to the liability;

3. "Domicile", for purposes of determining the state in which a purchasing group is domiciled, means:

- a. for a corporation, the state in which the purchasing group is incorporated, and
 - b. for an unincorporated entity, the state of its principal place of business;
4. "Hazardous financial condition" means that, based on its present or reasonably anticipated financial condition, a risk retention group, although not yet financially impaired or insolvent, is unlikely to be able:
- a. to meet obligations to policyholders with respect to known claims and reasonably anticipated claims, or
 - b. to pay other obligations in the normal course of business;
5. "Insurance" means primary insurance, excess insurance, reinsurance, surplus lines insurance, and any other arrangement for shifting and distributing risk which is determined to be insurance under the laws of this state;
6. "Liability":
- a. means legal liability for damages, including but not limited to, costs of defense, legal costs and fees, and other claims expenses, because of injuries to other persons, damage to their property, or other damage or loss to such other persons resulting from or arising out of:
 - (1) any for-profit or non-profit business, trade, product, services, premises, or operations, or
 - (2) any activity of any state or local government, or any agency or political subdivision thereof, and
 - b. does not include personal risk liability and the liability of an employer to employees, other than legal liability under the Federal Employers' Liability Act, 45 U.S.C. 51 et seq.;
7. "Personal risk liability" means liability for damages because of injury to any person, damage to property, or other loss or damage resulting from any personal, familial, or household responsibilities or activities rather than from responsibilities or activities referred to in paragraph 6 of this section;
8. "Plan of operation or feasibility study" means an analysis which presents the expected activities and results of a risk retention group including, but not limited to:
- a. for each state in which it intends to operate, the coverages, deductibles, coverage limits, rates, and rating classification systems for each line of insurance the group intends to offer,
 - b. historical and expected loss experience of the proposed members and national experience of similar exposures to the extent that this experience is reasonably available,

- c. pro forma financial statements and projections,
- d. appropriate opinions by a qualified independent casualty actuary, as defined in paragraph 11 of this section, including a determination of minimum premium or participation levels required to commence operations and to prevent a hazardous financial condition,
- e. identification of management procedures, underwriting and claims procedures, marketing methods, managerial oversight methods, investment policies, and reinsurance agreements,
- f. information sufficient to verify that its members are engaged in businesses or activities similar or related with respect to the liability to which such members are exposed by virtue of any related, similar, or common business, trade, product, services, premises, or operations,
- g. identification of each state in which the risk retention group has obtained, or sought to obtain, a charter and license, and a description of its status in each such state, and
- h. such other matters as may be prescribed by the Commissioner, for liability insurance companies authorized by the insurance laws of the state in which the risk retention group is chartered;

9. "Product liability" means liability for damages because of any personal injury, death, emotional harm, consequential economic damage, or property damage, including but not limited to damages resulting from the loss of use of property, arising out of the manufacture, design, importation, distribution, packaging, labeling, lease, or sale of a product, but does not include the liability of any person for those damages if the product involved was in the possession of such a person when the incident giving rise to the claim occurred;

10. "Purchasing group" means any group which:

- a. has as one of its purposes the purchase of liability insurance on a group basis,
- b. has as one of its purposes the purchase of liability insurance on a group basis for its members to cover their similar or related liability exposure,
- c. is composed of members whose businesses or activities are similar or related with respect to the liability to which members are exposed by virtue of any related, similar, or common business, trade, product, services, premises, or operations, and
- d. is domiciled in any state;

11. "Qualified actuary" means an individual who is a member of the American Academy of Actuaries and who has met the Qualification Standards for Actuaries Issuing Statements of Actuarial Opinions in the United States promulgated by the American Academy of Actuaries;

12. "Risk retention group" means any corporation or other limited liability association:

- a. whose primary activity consists of assuming and spreading all or any portion of the liability exposure of its group members,
- b. which is organized for the primary purpose of conducting the activity specified in subparagraph a of this paragraph,
- c. which is chartered and licensed as a liability insurance company and authorized to engage in the business of insurance under the laws of any state, or, before January 1, 1985, was chartered or licensed and authorized to engage in the business of insurance under the laws of Bermuda or the Cayman Islands and, before such date, had certified to the Insurance Commissioner of at least one state that it satisfied the capitalization requirements of such state, except that any such group shall be considered to be a risk retention group only if it has been engaged in business continuously since such date and only for the purpose of continuing to provide insurance to cover product liability or completed operations liability, as such terms were defined in the federal Product Liability Risk Retention Act of 1981, before the date of the enactment of the federal Liability Risk Retention Act of 1986,
- d. which does not exclude any person from membership in the group solely to provide for members of such group a competitive advantage over such person,
- e. (1) which has as its owners only persons who comprise the membership of the risk retention group, and
(2) has as its owners only persons who comprise the membership of the risk retention group and who are provided insurance by the group,
- f. whose members are engaged in businesses or activities similar or related with respect to the liability of which such members are exposed by virtue of any related, similar, or common business trade, product, services, premises, or operations,
- g. whose activities do not include the provision of insurance other than:

- (1) liability insurance for assuming and spreading all or any portion of the liability of its group members, and
- (2) reinsurance with respect to the liability of any other risk retention group, or any members of such other group engaged in businesses or activities so that the risk retention group or individual members of the group meet the requirements described in subparagraph f of this paragraph because of membership in the risk retention group that provides the reinsurance, and

h. the name of which includes the phrase, "Risk Retention Group"; and

13. "State" means any state of the United States or the District of Columbia.

Added by Laws 1987, c. 157, § 3, emerg. eff. June 25, 1987. Amended by Laws 2004, c. 334, § 1, emerg. eff. May 25, 2004; Laws 2018, c. 95, § 10, eff. Nov. 1, 2018; Laws 2021, c. 314, § 1, eff. Nov. 1, 2021.

§36-6454. Chartering and licensing of risk retention group.

A. 1. A risk retention group seeking to be chartered for domicile in this state shall be chartered and licensed only to write liability insurance pursuant to the insurance laws of this state and, except as provided elsewhere in the Oklahoma Risk Retention Act, shall comply with all of the laws, rules, regulations, and requirements applicable to such insurers chartered and licensed in this state including Section 6455 of this title to the extent such requirements are not a limitation on the laws, rules, regulations and requirements in this state.

2. Notwithstanding any other provision of law, all risk retention groups chartered in this state shall file with the Insurance Department and the National Association of Insurance Commissioners an annual statement in a form prescribed by the Association and in electronic form, if required by the Insurance Commissioner and completed in accordance with its instructions and the Practices and Procedures Manual of the Association.

B. Before it may offer insurance in any state, each risk retention group licensed in this state shall submit for approval to the Insurance Commissioner of this state a plan of operation or a feasibility study. The risk retention group shall submit an appropriate revision in the event of any subsequent material change in any item of the plan of operation or feasibility study within ten (10) days of the change. The group shall not offer any additional kinds of liability insurance in this state or in any other state until a revision of the plan or study is approved by the

Commissioner. At the time of filing its application for charter, the risk retention group shall provide to the Commissioner a summary of the following information: the identity of the initial members of the group or who organized the group, the identity of those individuals who will provide administrative services or otherwise influence or control the activities of the group, the amount and nature of initial capitalization, the coverages to be afforded, and the states in which the group intends to operate. Upon receipt of this information, the Commissioner shall transmit the information to the National Association of Insurance Commissioners. Transmitting this information shall be sufficient to satisfy the requirements of Section 6455 of this section.

Added by Laws 1987, c. 157, § 4, emerg. eff. June 25, 1987. Amended by Laws 2021, c. 314, § 2, eff. Nov. 1, 2021; Laws 2022, c. 154, § 9, eff. Nov. 1, 2022.

§36-6454.1. Risk retention groups - Governance standards.

A. For the purposes of this section:

1. "Board of Directors" or "Board" means the governing body of the risk retention group elected by the shareholders or members to establish policy, elect or appoint officers and committees, and make other governing decisions;

2. "Director" means a natural person designated in the articles of the risk retention group, or designated, elected or appointed by any other manner, name or title to act as a director;

3. "Disclose" means making information available through electronic or any other means the Board determines is necessary; and

4. "Service Providers" means captive managers, auditors, accountants, actuaries, investment advisors, lawyers, managing general underwriters or other parties responsible for underwriting, determination of rates, collection of premiums, adjusting and settling claims and/or the preparation of financial statements.

B. Existing risk retention groups shall comply with the following governance standards within one year of the effective date of this act. Risk retention groups licensed on or after the effective date of this act shall be in compliance with the standards at the time of licensure.

C. The Board of Directors of the risk retention group shall be composed of a majority of independent directors. No director shall qualify as independent unless the Board affirmatively determines that the director has no material relationship with the risk retention group. Each risk retention group shall disclose these determinations to its domestic regulator at least annually. Notwithstanding any other provision of law, a person that is a direct or indirect owner of or subscriber in the risk retention group, or is an officer, director or employee of such an owner and insured, is considered to be independent unless some other position

of such officer, director or employee constitutes a material relationship. Material relationship of a person with the risk retention group shall include, but is not limited to:

1. The receipt in any one twelve (12) month period of compensation or payment of any other item of value by such person, a member of such person's immediate family or any business with which the person is affiliated from the risk retention group or a consultant or service provider to the risk retention group is greater than or equal to five percent (5%) of the risk retention group's gross written premium for the twelve (12) month period or two percent (2%) of its surplus, whichever is greater, as measured at the end of any fiscal quarter falling in the twelve (12) month period. The person or immediate family member of such person is not independent until one year after his or her compensation from the risk retention group falls below the threshold provided in this paragraph.

2. A relationship with a director or an immediate family member of a director who is affiliated with or employed in a professional capacity by a present or former internal or external auditor of the risk retention group is not independent until one year after the end of the affiliation, employment or auditing relationship.

3. A relationship with a director or immediate family member of a director who is employed as an executive officer of another company where any of the risk retention group's present executives serve on the other company's Board of Directors is not independent until one year after the end of such service or the employment relationship.

D. The term of any material service provider contract with the risk retention group shall not exceed five (5) years. Any such contract, or its renewal, shall require the approval of the majority of the risk retention group's independent directors. The risk retention group's Board shall have the right to terminate any service provider, audit or actuarial contract at any time for cause after providing adequate notice as defined in the contract. The service provider contract is deemed material if the amount to be paid for the contract is greater than or equal to five percent (5%) of the risk retention group's annual gross written premium or two percent (2%) of its surplus, whichever is greater. For the purpose of this section, lawyer shall not include defense counsel retained by the risk retention group to defend claims, unless the amount of fees paid to such lawyers are material. No service provider contract violating the provisions prohibiting material relationships, as specified in subsection B of this section, shall be entered into unless the risk retention group has notified the Commissioner in writing of its intention to enter into such contract at least thirty (30) days prior and the Commissioner has not disapproved it within such period. To the extent permissible under

state law, service providers of a reciprocal risk retention group shall contract with the risk retention group.

If the risk retention group is a reciprocal risk retention group, then the attorney-in-fact would be required to adhere to the same standards regarding independence of operation and governance as imposed on the Board's advisory committee created pursuant to this section.

E. The risk retention group's Board shall adopt a written policy in the plan of operation, as approved by the Board, that requires the Board to:

1. Assure that all owners and insureds of the risk retention group receive evidence of ownership interest;

2. Develop a set of governance standards applicable to the risk retention group;

3. Oversee the evaluation of the risk retention group's management including but not limited to the performance of the captive manager, managing general underwriter or other party or parties responsible for underwriting, determination of rates, collection of premium, adjusting or settling claims or the preparation of financial statements;

4. Review and approve the amount to be paid for all material service providers; and

5. Review and approve, at least annually:

a. the risk retention group's goals and objectives relevant to the compensation of officers and service providers,

b. the officers' and service providers' performance considering those goals and objectives, and

c. the continued engagement of the officers and material service providers.

F. 1. The risk retention group shall have an audit committee composed of at least three independent Board members, as specified in subsection C of this section. A nonindependent Board member may participate in the activities of the audit committee, if invited by the members, but shall not be a member of the committee.

2. The audit committee shall have a written charter that defines the purpose of the committee that includes but is not limited to:

a. assisting Board oversight of:

i. the integrity of the financial statements,

ii. the compliance with legal and regulatory requirements, and

iii. the qualifications, independence and performance of the independent auditor and actuary,

b. discussing the annual audited financial statements and quarterly financial statements with management,

- c. discussing the annual audited financial statements with its independent auditor and, if advisable, discuss its quarterly financial statements with its independent auditor,
- d. discussing policies with respect to risk assessment and risk management,
- e. meeting separately and periodically, either directly or through a designated representative of the committee, with management and independent auditors,
- f. reviewing with the independent auditor any audit problems or difficulties and management's response,
- g. setting clear hiring policies of the risk retention group as to the hiring of employees or former employees of the independent auditor,
- h. requiring the external auditor to rotate the head audit partner having primary responsibility for the risk retention group's audit, as well as the audit partner responsible for reviewing that audit so that neither individual performs audit services for more than five (5) consecutive fiscal years, and
- i. reporting regularly to the Board.

3. The domestic regulator may waive the requirement to establish an audit committee if the risk retention group is able to demonstrate to the domestic regulator that it is impracticable to do so and the risk retention group's Board is able to accomplish the purposes of an audit committee described in this subsection.

G. The Board shall adopt and disclose governance standards and provide the information to members and insureds upon request, which shall include but not be limited to:

- 1. A process by which the directors are elected by the owner and insureds;
- 2. Director qualification standards;
- 3. Director responsibilities;
- 4. Director access to management and, as necessary and appropriate, independent advisors;
- 5. Director compensation;
- 6. Director orientation and continuing education;
- 7. The policies and procedures that are followed for management succession; and
- 8. The policies and procedures that are followed for annual performance evaluation of the Board.

H. The Board shall adopt and disclose a code of business conduct and ethics for directors, officers and employees of the risk retention group and shall promptly disclose to the Board any waivers of the code for directors or executive officers, which shall include the following topics:

- 1. Conflicts of interest;

2. Matters covered under the corporate opportunities doctrine under the state of domicile;

3. Confidentiality;

4. Fair dealing;

5. Protection and proper use of risk retention group assets;

6. Compliance with all applicable laws, rules and regulations;

and

7. Requiring the reporting of any illegal or unethical behavior which affects the operation of the risk retention group.

I. The captive manager, president or chief executive officer of the risk retention group shall promptly notify the domestic regulator in writing if either becomes aware of any material noncompliance with the governance standards specified in subsections G and H of this section.

Added by Laws 2021, c. 314, § 3, eff. Nov. 1, 2021.

§36-6455. Conditions for doing business in state - Prohibited acts.

Risk retention groups chartered and licensed in states other than this state and seeking to do business as risk retention groups in this state shall observe and abide by the laws of this state as follows:

A. Before offering insurance in this state, a risk retention group shall submit to the Commissioner of this state, on a form prescribed by the National Association of Insurance Commissioners of this state:

1. A statement identifying the state or states in which the risk retention group is chartered and licensed as a liability insurance company, the date of chartering, its principal place of business, and such other information, including information on its membership, as the Commissioner of this state may require to verify that the group is qualified to be licensed as a risk retention group;

2. A copy of its plan of operation or a feasibility study and revisions of such plan or study submitted to its state of domicile; provided, however, that the provision relating to the submission of a plan of operation or a feasibility study shall not apply with respect to any line or classification of liability insurance which:

a. was defined in the federal Product Liability Risk Retention Act of 1981 before October 27, 1986, and

b. was offered before such date by a risk retention group which had been chartered and operating for not less than three (3) years before such date;

3. A copy of any material revision to its plan of operation or feasibility study required by subsection B of Section 6454 within thirty (30) days of the date of approval of the revision by the Insurance Commissioner of its chartering state, or within thirty (30) days of filing if no such approval is required; and

4. A statement of registration which designates the Commissioner of this state as its agent for the purpose of receiving service of legal documents or process. The risk retention group shall pay a filing fee, in an amount determined by the Commissioner.

B. Any risk retention group doing business in this state shall submit to the Commissioner of this state:

1. A copy of the group's financial statement submitted to its state of domicile, which shall be certified by an independent public accountant or certified public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or a loss reserve specialist qualified pursuant to criteria established by the National Association of Insurance Commissioners;

2. A copy of each examination of the risk retention group as certified by a Commissioner or public official conducting the examination;

3. Upon request by the Commissioner of this state, a copy of any audit performed with respect to the risk retention group; and

4. Such information as may be required to verify its continuing qualification as a risk retention group.

C. 1. Each risk retention group shall be liable for the payment of premium taxes and taxes on premiums of direct business for risk, and shall be subject to taxation at the same rate and subject to the same interest, fines, and penalties for nonpayment as that applicable to foreign admitted insurers.

2. To the extent licensed agents or brokers are utilized pursuant to Section 6462 of this title, they shall report to the Commissioner premiums for direct business for risks resident or located within the state which the licensees have placed with or on behalf of a risk retention group not chartered in this state.

3. To the extent that insurance agents or brokers are utilized pursuant to Section 6462 of this title, each agent or broker shall keep a complete and separate record of all policies procured from each such risk retention group, which record must be open to examination by the Insurance Commissioner or a designee of the Insurance Commissioner or a representative of the Insurance Commissioner on demand. These records shall, for each policy and each kind of insurance provided thereunder, include the following:

- a. the limit of liability,
- b. the time period covered,
- c. the effective date,
- d. the name of the risk retention group which issued the policy,
- e. the gross premium charged, and
- f. the amount of return premiums, if any.

D. Any risk retention group, its agents and representatives shall comply with the provisions of the Unfair Claims Settlement Practices Act of this state.

E. Any risk retention group shall comply with the laws of this state regarding deceptive, false or fraudulent acts or practices. However, if the Commissioner of this state seeks an injunction regarding such conduct, the injunction shall be obtained from a court of competent jurisdiction.

F. Any risk retention group shall submit to an examination by the Commissioner of this state to determine its financial condition if the Commissioner of the jurisdiction in which the group is chartered has not initiated an examination or does not initiate an examination within sixty (60) days after a request to do so is made by the Commissioner of this state. Any such examination shall be coordinated to avoid unjustified repetition of examination by Commissioners of other states and shall be conducted in an expeditious manner and in accordance with the National Association of Insurance Commissioner's Examiner Handbook.

G. Every application form for insurance from a risk retention group and every policy issued by a risk retention group shall contain in ten-point type on the front page and the declaration page, the following notice:

NOTICE

This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group.

H. The following acts by a risk retention group are hereby prohibited:

1. The solicitation or sale of insurance by a risk retention group to any person who is not eligible for membership in such group; and

2. The solicitation or sale of insurance by, or operation of, a risk retention group that is in a hazardous financial condition or is financially impaired.

I. No risk retention group shall be allowed to do business in this state if an insurance company is directly or indirectly a member or owner of such risk retention group, other than in the case of a risk retention group all of whose members are insurance companies.

J. The terms of any insurance policy offered by a risk retention group shall not provide, or be construed to provide, coverage prohibited generally by the Insurance Code or any other law of this state or declared unlawful by the highest court of this state whose law applies to insurance policy.

K. A risk retention group which is not chartered in this state but is doing business in this state shall comply with a lawful order

issued in a voluntary dissolution proceeding or in a delinquency proceeding commenced by an Insurance Commissioner of any state if there has been a finding of financial impairment after an examination by any state Insurance Commissioner under subsection F of this section.

Added by Laws 1987, c. 157, § 5, emerg. eff. June 25, 1987. Amended by Laws 2004, c. 334, § 2, emerg. eff. May 25, 2004; Laws 2021, c. 314, § 4, eff. Nov. 1, 2021.

§36-6456. Membership in or participation in insurance insolvency guaranty fund prohibited - Purchasing group coverage - Risks not covered.

A. No risk retention group shall be permitted to join or contribute financially to any insurance insolvency guaranty fund, or similar mechanism, in this state, nor shall any risk retention group, or its insureds or claimants against its insureds, receive any benefit from any such fund for claims arising under the insurance policies issued by a risk retention group.

B. When a purchasing group obtains insurance covering its members' risks from an insurer not authorized in this state or a risk retention group, no such risks, wherever resident is located, shall be covered by any insurance guaranty fund or similar mechanism in this state.

C. When a purchasing group obtains insurance covering its members' risks from an authorized insurer, only risks resident or located in this state may be covered by the Oklahoma Property and Casualty Insurance Guaranty Association.

Added by Laws 1987, c. 157, § 6, emerg. eff. June 25, 1987. Amended by Laws 2004, c. 334, § 3, emerg. eff. May 25, 2004; Laws 2021, c. 314, § 5, eff. Nov. 1, 2021.

§36-6456.1. Countersign not required.

Notwithstanding any other provision of law, a policy of insurance issued to a risk retention group or any member of that group shall not be required to be countersigned.

Added by Laws 2021, c. 314, § 6, eff. Nov. 1, 2021.

§36-6457. Exemptions.

A purchasing group and its insurer or insurers shall be subject to all applicable laws of this state, except that a purchasing group and its insurer or insurers shall be exempt, in regard to liability insurance for the purchasing group, from any law of this state that would:

1. Prohibit the establishment of a purchasing group;
2. Make unlawful an insurer providing advantages to a purchasing group or its members based on the loss and expense experience of the group or its members including but not limited to

advantages on rates, policy forms and coverage, that is not afford to other persons or entities;

3. Prohibit a purchasing group or its members from purchasing insurance on a group basis described in paragraph 1 of this section;

4. Prohibit a purchasing group from obtaining insurance on a group basis because the group has not been in existence for a minimum period of time or because any member has not belonged to the group for a minimum period of time;

5. Require that a purchasing group must have a minimum number of members, common ownership or affiliation, or certain legal form;

6. Require that a certain percentage of a purchasing group must obtain insurance on a group basis;

7. Otherwise discriminates against a purchasing group or any of its members; or

8. Require that any insurance policy issued to a purchasing group or any of its members be countersigned by an insurance agent or broker residing in this state.

A purchasing group shall be subject to all other applicable laws of this state.

Added by Laws 1987, c. 157, § 7, emerg. eff. June 25, 1987. Amended by Laws 2004, c. 334, § 4, emerg. eff. May 25, 2004; Laws 2021, c. 314, § 7, eff. Nov. 1, 2021.

§36-6458. Notice to Commissioner - Designation and registration of agent.

A. A purchasing group which intends to do business in this state shall, prior to doing business, furnish to the Insurance Commissioner notice which shall, on forms prescribed by the National Association of Insurance Commissioners:

1. Identify the state in which the group is domiciled;

2. Identify all other states in which the group intends to do business;

3. Specify the lines and classifications of liability insurance which the purchasing group intends to purchase;

4. Identify the insurance company or companies from which the group intends to purchase its insurance and the domicile of the company or companies;

5. Identify the principal place of business of the group;

6. Specify the method by which the person or persons, if any, through whom insurance will be offered to its members whose risks are resident or located in this state; and

7. Provide such other information as may be required by the Commissioner of this state to verify that the purchasing group is qualified to do business in this state as a purchasing group.

B. A purchasing group shall notify the Insurance Commissioner of any changes in any of the information prescribed in subsection A of this section within ten (10) days of such change;

C. The purchasing group shall register with and designate the Commissioner of this state as its agent solely for the purpose of receiving service of legal documents or process, for which a filing fee shall be assessed in an amount determined by the Commissioner, except that such requirements shall not apply in the case of a purchasing group which only purchases insurance that was authorized under the federal Products Liability Risk Retention Act of 1981 and:

1. Which:

- a. was domiciled before April 1, 1986, and
- b. is domiciled on and after October 27, 1986, in any state;

2. Before October 27, 1986, purchased insurance from an insurance carrier licensed in any state;

3. Since October 27, 1986, purchased its insurance from an insurance carrier licensed in any state; or

4. Was a purchasing group pursuant to the requirements of the federal Product Liability Risk Retention Act of 1981 before October 27, 1986.

D. Each purchasing group that is required to give notice pursuant to subsection A of this section also shall furnish such information as may be required by the Insurance Commissioner or designee to:

1. Verify that the entity qualifies as a purchasing group;
2. Determine where the purchasing group is located; and
3. Determine appropriate tax treatment.

Added by Laws 1987, c. 157, § 8, emerg. eff. June 25, 1987. Amended by Laws 2004, c. 334, § 5, emerg. eff. May 25, 2004; Laws 2021, c. 314, § 8, eff. Nov. 1, 2021.

§36-6459. Effectuation of purchase through licensed broker or agent - Notice of risks not covered - Deductibles or self-insured retention - Aggregate limits standards.

A. A purchasing group shall not purchase insurance from a risk retention group that is not chartered in a state or from an insurer not licensed to transact insurance in this state, unless the purchase is effected through a licensed agent or broker acting pursuant to the surplus lines laws and regulations of this state.

B. A purchasing group which obtains liability insurance from an insurer not admitted in this state or a risk retention group shall inform each of the members of the group which has a risk resident or located in this state that the risk is not protected by an insurance insolvency guaranty fund in this state and that the risk retention group or the insurer may not be subject to all insurance laws and regulations of this state.

C. No purchasing group may purchase insurance providing for a deductible or self-insured retention applicable to the group as a

whole. However, coverage may provide for a deductible or self-insured retention applicable to individual members.

D. Purchases of insurance by purchasing groups are subject to the same standards regarding aggregate limits which are applicable to all purchases of group insurance.

Added by Laws 1987, c. 157, § 9, emerg. eff. June 25, 1987. Amended by Laws 1991, c. 146, § 7, eff. Sept. 1, 1991; Laws 2003, c. 150, § 7, eff. Nov. 1, 2003; Laws 2004, c. 334, § 6, emerg. eff. May 25, 2004; Laws 2021, c. 314, § 9, eff. Nov. 1, 2021.

§36-6459.1. Premium taxes.

Premium taxes and taxes on premiums paid for coverage of risks resident or located in this state by a purchasing group or any members of the purchasing group shall be:

1. Imposed at the same rate and subject to the same interest, fines and penalties as applicable to premium taxes and taxes on premiums paid for similar coverage from a similar insurance source; and

2. Paid by the insurance source, the agent or broker for the purchasing group, the purchasing group or any members of the purchasing group.

Added by Laws 2021, c. 314, § 10, eff. Nov. 1, 2021.

§36-6460. Enforcement powers of Commissioner.

The Insurance Commissioner of this state is authorized to make use of any of the powers established pursuant to the Insurance Code of this state to enforce the laws of this state so long as those powers are not specifically preempted by the Risk Retention Act of 1986, as amended, including the administrative authority of the Commissioner to investigate, issue subpoenas, conduct depositions and hearings, issue orders, impose penalties and seek injunctive relief. Regarding any investigation, administrative proceedings or litigation, the Commissioner may rely on the procedural laws of this state. The injunctive authority of the Commissioner for risk retention groups is restricted by the requirement that any injunction be issued by a court of competent jurisdiction.

Added by Laws 1987, c. 157, § 10, emerg. eff. June 25, 1987.

Amended by Laws 1997, c. 418, § 117, eff. Nov. 1, 1997; Laws 2021, c. 314, § 11, eff. Nov. 1, 2021.

§36-6461. Violations - Penalties.

A. A risk retention group which violates any provision of the Oklahoma Risk Retention Act shall be subject to fines and penalties applicable to licensed insurers generally, including but not limited to revocation of license and the authority to transact insurance business in this state.

B. A risk retention group doing business in this state that is not licensed pursuant to the Oklahoma Risk Retention Act shall be considered an unauthorized insurer and shall be subject to the provisions of applicable sections of the Insurance Code pertaining to unauthorized insurers.

C. A purchasing group that is registered pursuant to the Oklahoma Risk Retention Act and which violates any provision of said act shall be subject to a fine of up to One Thousand Dollars (\$1,000.00) and censure, suspension, or revocation of license or by both such fine and licensure proceedings, after notice and hearing.

D. A purchasing group doing business in this state which is not registered shall be considered an unauthorized insurer and subject to the provisions of applicable sections of the Insurance Code pertaining to unauthorized insurers.

Added by Laws 1987, c. 157, § 11, emerg. eff. June 25, 1987.

§36-6462. License required before commencing business activity - Soliciting liability insurance for purchasing groups.

A. No person, firm, association or corporation shall act or aid in any manner in soliciting, negotiating, or procuring liability insurance in this state from a risk retention group unless such person, firm, association or corporation is licensed as an insurance agent or a broker, pursuant to the Oklahoma Insurance Code.

B. 1. No person, firm, association or corporation shall act or aid in any manner in soliciting, negotiating, or procuring liability insurance coverage in this state for a purchasing group from an authorized insurer or a risk retention group unless such person, firm, association or corporation is licensed as an insurance agent or a broker pursuant to the Oklahoma Insurance Code.

2. No person, firm, association or corporation shall act or aid in any manner in soliciting, negotiating, or procuring liability insurance coverage in this state from any member of a purchasing group under a policy of a purchasing group unless such person, firm, association or corporation is licensed as an insurance agent or a broker pursuant to the Oklahoma Insurance Code.

3. No person, firm, association or corporation shall act or aid in any manner in soliciting, negotiating or procuring liability insurance from an insurer not authorized to do business in this state on behalf of a purchasing group located in this state unless the person, firm, association or corporation is licensed as a surplus lines agent or excess line broker pursuant to the Oklahoma Insurance Code.

C. For purposes of acting as an agent or broker for a risk retention group or purchasing group pursuant to subsections A and B of this section, the requirement of residence in this state shall not apply.

D. Every person licensed as an agent or broker as required in this section, on business placed with risk retention groups or written through a purchasing group, shall inform each prospective insured of the provisions of the notice required by the Oklahoma Risk Retention Act.

Added by Laws 1987, c. 157, § 12, emerg. eff. June 25, 1987.

Amended by Laws 2004, c. 334, § 7, emerg. eff. May 25, 2004; Laws 2021, c. 314, § 12, eff. Nov. 1, 2021.

§36-6463. Assets to protect purchasers.

The State Insurance Commissioner shall require all risk insurance groups to have appropriate reserves in Oklahoma, other assets, or a corporate surety bond to protect purchasers in case of bankruptcy, withholding of unearned premiums, or failure to pay benefits.

Added by Laws 1987, c. 157, § 13, emerg. eff. June 25, 1987.

§36-6464. Enforcement of court orders.

An order issued by any District Court of the United States enjoining a risk retention group from soliciting or selling insurance, or operating in any state, or in any territory or possession of the United States, upon a finding that such a group is in a hazardous financial condition or financially impaired shall be enforceable in the courts of this state.

Added by Laws 1987, c. 157, § 14, emerg. eff. June 25, 1987.

Amended by Laws 2021, c. 314, § 13, eff. Nov. 1, 2021.

§36-6465. Fees.

There shall be collected, at the time of filing of information for a risk retention group, a fee payable annually, of Four Hundred Dollars (\$400.00). In addition, risk retention groups chartered for domicile in this state shall pay the same fees applicable to insurers in this state.

Purchasing groups shall pay annually at the time of registration, a fee of Four Hundred Dollars (\$400.00).

Added by Laws 1987, c. 157, § 15, emerg. eff. June 25, 1987.

Amended by Laws 2009, c. 432, § 22, eff. July 1, 2009.

§36-6466. Rules.

The Commissioner may establish and from time to time amend such rules relating to risk retention groups and purchasing groups as may be necessary or desirable to implement the provisions of the Oklahoma Risk Retention Act.

Added by Laws 1987, c. 157, § 16, emerg. eff. June 25, 1987.

§36-6467. Reciprocal agreements.

The Commissioner may make reciprocal agreements with other states to further the purposes of this act.
Added by Laws 1987, c. 157, § 17, emerg. eff. June 25, 1987.

§36-6468. Workers' compensation group self-insurance associations exempted.

The provisions of this act shall not apply to workers' compensation group self-insurance associations.

Added by Laws 1987, c. 157, § 18, emerg. eff. June 25, 1987.

§36-6470.1. Short title.

Sections 6470.1 through 6470.33 of this title shall be known and may be cited as the "Oklahoma Captive Insurance Company Act".

Added by Laws 2004, c. 334, § 8, emerg. eff. May 25, 2004. Amended by Laws 2006, c. 265, § 1, eff. Nov. 1, 2006.

§36-6470.2. Definitions.

As used in the Oklahoma Captive Insurance Company Act:

1. "Alien company" means an insurance company formed and licensed pursuant to the laws of a country or jurisdiction other than the United States of America, or any of its states, districts, commonwealths and possessions;

2. "Affiliated company" means a company in the same corporate system as a parent, an industrial insured, or a member organization by virtue of common ownership, control, operation, or management;

3. "Association" means a legal association of individuals, corporations, partnerships, or associations that has been in continuous existence for at least one (1) year or such lesser period of time approved by the Commissioner:

- a. the member organizations of which, or which does itself or either of them acting in concert directly or indirectly own, control, or hold with power to vote all of the outstanding voting securities or interests of, or have complete voting control over an association captive insurance company, or
- b. the member organizations of which collectively constitute all of the subscribers of an association captive insurance company formed as a reciprocal insurer;

4. "Association captive insurance company" means a captive insurance company that insures risks of the member organizations of the association and their affiliated companies;

5. "Branch business" means any insurance business transacted by a branch captive insurance company in this state;

6. "Branch captive insurance company" means an alien captive insurance company licensed by the Insurance Commissioner to transact the business of insurance in this state through a business unit with

a principal place of business in this state. A branch captive insurance company must be a pure captive insurance company with respect to operations in this state, unless otherwise permitted by the Insurance Commissioner;

7. "Branch operations" means any business operations of a branch captive insurance company in this state;

8. "Capital and surplus" means the amount by which the value of all of the assets of the captive insurance company exceeds all of the liabilities of the captive insurance company, as determined under the method of accounting utilized by the captive insurance company in accordance with the applicable provisions of this act;

9. "Captive insurance company" means a pure captive insurance company, association captive insurance company, sponsored captive insurance company, special purpose captive insurance company, industrial insured captive insurance company, branch captive insurance company, or series captive insurance company formed or licensed under the Oklahoma Captive Insurance Company Act;

10. "Controlled unaffiliated business" means a company:

- a. that is not in the corporate system of a parent and affiliated companies,
- b. that has an existing contractual relationship with a parent or affiliated company, and
- c. whose risks are managed by a pure captive insurance company in accordance with Section 6470.27 of this title;

11. "Insurance Commissioner" means the Insurance Commissioner of this state or designee of the Insurance Commissioner;

12. "Department" means the Insurance Department;

13. "GAAP" means generally accepted accounting principles;

14. "Industrial insured" means an insured:

- a. who procures the insurance of any risk or risks by use of the services of a full-time employee acting as an insurance manager or buyer,
- b. whose aggregate annual premiums for insurance on all risks total at least Twenty-five Thousand Dollars (\$25,000.00), and
- c. who has at least twenty-five full-time employees;

15. "Industrial insured captive insurance company" means a company that insures risks of the industrial insureds that comprise the industrial insured group and their affiliated companies;

16. "Industrial insured group" means a group of industrial insureds that collectively directly or indirectly owns, controls, or holds with power to vote all of the outstanding voting securities or other voting interests or has complete control over an industrial insured captive insurance company;

17. "Member organization" means any individual, corporation, partnership, or association that belongs to an association;

18. "Parent" means any corporation, partnership, or individual that directly or indirectly owns, controls, or holds with power to vote more than fifty percent (50%) of the outstanding voting securities of a pure captive insurance company;

19. "Participant" means an entity as defined in Section 6470.31 of this title, and any affiliates of that entity, that are insured by a sponsored captive insurance company, where the losses of the participant are limited through a participant contract to the participant's pro rata share of the assets of one or more protected cells identified in the participant contract;

20. "Participant contract" means a contract by which a sponsored captive insurance company insures the risks of one or more participants and limits the losses of each participant to its pro rata share of the assets of one or more protected cells identified in the participant contract;

21. "Protected cell" means a separate and distinct account established and maintained by or on behalf of a sponsored captive insurance company in which assets are accounted for and recorded for one or more participants in accordance with the terms of one or more participant contracts to fund the liability of the sponsored captive insurance company assumed on behalf of the participants as set forth in the participant contracts;

22. "Pure captive insurance company" means a company that insures risks of its parent, affiliated companies of its parent, and any controlled unaffiliated business, or a combination thereof. For purposes of this paragraph, "controlled unaffiliated business" means an entity insured by a pure captive insurance company:

- a. that is not in the corporate system of a parent and affiliated companies,
- b. that has an existing contractual relationship with a parent or affiliated company, and
- c. whose risks are managed by a pure captive insurance company;

23. "Reciprocal insurer" has the meaning given that term in Article 29 of the Oklahoma Insurance Code;

24. "Risk retention group" means a risk retention group formed pursuant to the Liability Risk Retention Act of 1986 under Section 3901 of Title 15 of the United States Code;

25. "Series" means a series of members, managers, membership interests or assets under the Oklahoma Limited Liability Company Act pursuant to Section 2054.4 of Title 18 of the Oklahoma Statutes, or the corresponding law of another state;

26. "Series captive insurance company" means a series which has received a certificate of authority pursuant to this act;

27. "Special purpose captive insurance company" means a captive insurance company that is formed or licensed under the Oklahoma Captive Insurance Company Act that does not meet the definition of

any other type of captive insurance company defined in this section and is designated as a special purpose captive insurance company by the Commissioner;

28. "Sponsor" means an entity that meets the requirements of Section 6470.30 of this title and is approved by the Insurance Commissioner to provide all or part of the capital and surplus required by applicable law and to organize and operate a sponsored captive insurance company;

29. "Sponsored captive insurance company" means a captive insurance company:

- a. in which the minimum capital and surplus required by applicable law is provided by one or more sponsors,
- b. that is formed or licensed under the Oklahoma Captive Insurance Company Act,
- c. that insures the risks of its participants only through separate participant contracts, and
- d. that funds its liability to each participant through one or more protected cells and segregates the assets of each protected cell from the assets of other protected cells and from the assets of the sponsored captive insurance company's general account; and

30. "Workers' compensation insurance" means insurance provided in satisfaction of an employer's responsibility as set forth in the Administrative Workers' Compensation Act and the Oklahoma Employee Injury Benefit Act.

Added by Laws 2004, c. 334, § 9, emerg. eff. May 25, 2004. Amended by Laws 2013, c. 41, § 5, eff. Nov. 1, 2013; Laws 2015, c. 298, § 14, eff. Nov. 1, 2015; Laws 2016, c. 73, § 12, eff. Nov. 1, 2016; Laws 2021, c. 314, § 14, eff. Nov. 1, 2021; Laws 2022, c. 127, § 1, eff. Nov. 1, 2022.

§36-6470.3. License - Limitations on risks covered - Requirements for conducting business in state - Information required - Fees - Provisional license.

A. A captive insurance company, when permitted by its articles of incorporation or charter, may apply to the Insurance Commissioner for a license to do any and all insurance authorized by this title; however:

1. A pure captive insurance company may not insure any risks other than those of its parent, affiliated companies of its parent, or any controlled unaffiliated business, or a combination thereof;
2. An association captive insurance company may not insure any risks other than those of the member organizations of its association and their affiliated companies;
3. An industrial insured captive insurance company may not insure any risks other than those of the industrial insureds that

comprise the industrial insured group and their affiliated companies;

4. A special purpose captive insurance company may provide insurance or reinsurance, or both, for risks as approved by the Insurance Commissioner;

5. A captive insurance company may not provide personal motor vehicle or homeowner's insurance coverage or any component of these coverages;

6. Any captive insurance company may provide workers' compensation insurance, insurance in the nature of workers' compensation insurance, and reinsurance of such policies, unless prohibited by federal law or laws of this state or any other state having jurisdiction over the transaction; and

7. A series captive insurance company may not insure any risks other than those permitted in paragraphs 1 through 6 of this subsection. A series may elect to apply for a certificate of authority as an association captive insurance company, industrial insured captive insurance company, a pure captive insurance company, series captive insurance company, or a special purpose captive insurance company.

B. To conduct insurance business in this state a captive insurance company shall:

1. Obtain from the Insurance Commissioner a license authorizing it to conduct insurance business in this state;

2. Maintain a place of business in this state designated as its registered office; and

3. Appoint a resident registered agent to accept service of process and to otherwise act on its behalf in this state. Whenever the registered agent cannot with reasonable diligence be found at the registered office of the captive insurance company, the Insurance Commissioner shall be deemed an agent of the captive insurance company upon whom any process, notice, or demand may be served.

C. 1. Before receiving a license, a captive insurance company shall file with the Commissioner a certified copy of its organizational documents, a statement under oath of its president or other authorized person showing its financial condition, a feasibility study, a business plan, and any other statements, information or documents required by the Commissioner.

2. In addition to the information required by paragraph 1 of this subsection, an applicant captive insurance company shall file with the Insurance Commissioner evidence of:

- a. the amount and liquidity of its assets relative to the risks to be assumed,
- b. the adequacy of the expertise, experience, and character of the person or persons who will manage it,
- c. the overall soundness of its plan of operation,

- d. the adequacy of the loss prevention programs of its insureds, and
- e. such other factors considered relevant by the Insurance Commissioner in ascertaining whether the proposed captive insurance company will be able to meet its obligations.

3. Information submitted pursuant to this subsection is confidential and may not be made public by the Insurance Commissioner or an agent or employee of the Insurance Commissioner without the written consent of the company, except that:

- a. information may be discoverable by a party in a civil action or contested case to which the captive insurance company that submitted the information is a party, upon a showing by the party seeking to discover the information that:
 - (1) the information sought is relevant to and necessary for the furtherance of the action or case,
 - (2) the information sought is unavailable from other nonconfidential sources, and
 - (3) a subpoena issued by a judicial or administrative officer of competent jurisdiction has been submitted to the Insurance Commissioner; however, the provisions of this paragraph do not apply to an industrial insured captive insurance company insuring the risks of an industrial insured group, and
- b. the Insurance Commissioner may disclose the information to a public officer having jurisdiction over the regulation of insurance in another state if:
 - (1) the public official agrees in writing to maintain the confidentiality of the information, and
 - (2) the laws of the state in which the public official serves require the information to be confidential.

D. Except for a special purpose captive insurance company, a captive insurance company shall pay to the Department a nonrefundable application fee of Two Hundred Dollars (\$200.00) for reviewing its application to determine whether it is complete and in addition, the Insurance Commissioner may retain legal, financial, and examination services from outside the Department, the reasonable cost of which may be charged against the applicant. A special purpose captive insurance company shall pay to the Department a nonrefundable fee of Three Hundred Dollars (\$300.00). Also, a captive insurance company shall pay a license fee for the year of registration and a renewal fee of Three Hundred Dollars (\$300.00).

E. If the Insurance Commissioner is satisfied that the documents and statements filed by the captive insurance company comply with the provisions of the Oklahoma Captive Insurance Company Act, the Insurance Commissioner may grant a license authorizing the company to do insurance business in this state until the succeeding March 1 at which time the license may be renewed.

F. 1. Notwithstanding any other provision of this act, the Insurance Commissioner may issue a provisional license to any applicant captive insurance company if the Insurance Commissioner deems that the public interest will be served by the issuance of such license.

2. As a condition precedent to the issuance of a provisional license under this section, the applicant shall have filed a complete application containing all information required by this section, paid all fees required for licensure and the Insurance Commissioner shall have made a preliminary finding that the expertise, experience and character of the person or persons who will control and manage the applicant captive insurer are acceptable.

3. The Insurance Commissioner may by order limit the authority of any provisional licensee in any way deemed necessary to protect insureds and the public. The Insurance Commissioner may by order revoke a provisional license if the interests of insureds or the public are endangered. If the applicant fails to complete the regular licensure application process, the provisional license shall terminate automatically.

Added by Laws 2004, c. 334, § 10, emerg. eff. May 25, 2004. Amended by Laws 2006, c. 265, § 2, eff. Nov. 1, 2006; Laws 2012, c. 365, § 5, emerg. eff. June 8, 2012; Laws 2013, c. 41, § 6, Nov. 1, 2013; Laws 2015, c. 298, § 15, eff. Nov. 1, 2015; Laws 2016, c. 73, § 13, eff. Nov. 1, 2016; Laws 2018, c. 306, § 2; Laws 2021, c. 314, § 15, eff. Nov. 1, 2021; Laws 2022, c. 127, § 2, eff. Nov. 1, 2022.

§36-6470.4. Repealed by Laws 2013, c. 41, § 24, eff. Nov. 1, 2013.

§36-6470.5. Adoption of same or confusing name.

A captive insurance company may not adopt a name that is the same as, deceptively similar to, or likely to be confused with or mistaken for any other existing business name registered in this state.

Added by Laws 2004, c. 334, § 12, emerg. eff. May 25, 2004.

§36-6470.6. Unimpaired paid-in capital requirements - Branch companies - Trust funds - Dividends and distributions - Approval required.

A. The Insurance Commissioner may not issue or renew the license of a captive insurance company unless the company possesses

and thereafter maintains unimpaired aggregate paid-in capital and surplus of:

1. In the case of a pure captive insurance company, not less than Two Hundred Fifty Thousand Dollars (\$250,000.00), One Hundred Fifty Thousand Dollars (\$150,000.00) of which must be paid-in prior to the issuance of a license, and an additional One Hundred Thousand Dollars (\$100,000.00) of which must be paid-in on or before the first anniversary of the issuance of the initial license;

2. In the case of an association captive insurance company incorporated as a stock insurer, not less than Seven Hundred Fifty Thousand Dollars (\$750,000.00);

3. In the case of an industrial insured captive insurance company incorporated as a stock insurer, not less than Five Hundred Thousand Dollars (\$500,000.00);

4. In the case of a sponsored captive insurance company, not less than Five Hundred Thousand Dollars (\$500,000.00);

5. In the case of any captive insurance company doing business as a risk retention group, not less than One Million Dollars (\$1,000,000.00); and

6. In the case of a special purpose or branch captive insurance company, not less than Two Hundred Fifty Thousand Dollars (\$250,000.00) or an amount determined by the Insurance Commissioner after giving due consideration to the business plan of the company, feasibility study, and pro formas, including the nature of the risks to be insured;

7. In the case of a series captive insurance company, the minimum capital and surplus shall be in an amount specified by the Insurance Commissioner; and

8. The unimpaired paid-in capital may be in the form of cash, cash equivalent, or an irrevocable letter of credit issued by a bank chartered by this state or a member bank of the Federal Reserve System. The issuing bank shall be approved by the Insurance Commissioner.

B. The Insurance Commissioner may prescribe additional capital and surplus based upon the type, volume, and nature of insurance business transacted.

C. In the case of a branch captive insurance company, as security for the payment of liabilities attributable to branch operations, the Insurance Commissioner may require that a trust fund, funded by an irrevocable letter of credit or other acceptable asset, be established and maintained in the United States for the benefit of United States policyholders and United States ceding insurers. The amount of the security may be no less than the capital and surplus required by the Oklahoma Captive Insurance Company Act and the reserves on these insurance policies or reinsurance contracts.

D. A captive insurance company may not pay a dividend out of, or other distribution with respect to, capital or surplus, without the prior approval of the Insurance Commissioner. Approval of an ongoing plan for the payment of dividends or other distributions must be conditioned upon the retention, at the time of each payment, of capital or surplus in excess of amounts specified by, or determined in accordance with formulas approved by, the Insurance Commissioner.

Added by Laws 2004, c. 334, § 13, emerg. eff. May 25, 2004. Amended by Laws 2013, c. 41, § 7, eff. Nov. 1, 2013; Laws 2015, c. 298, § 16, eff. Nov. 1, 2015; Laws 2021, c. 314, § 16, eff. Nov. 1, 2021.

§36-6470.7. Repealed by Laws 2013, c. 41, § 24, eff. Nov. 1, 2013.

§36-6470.8. Repealed by Laws 2013, c. 41, § 24, eff. Nov. 1, 2013.

§36-6470.9. Repealed by Laws 2013, c. 41, § 24, eff. Nov. 1, 2013.

§36-6470.10. Formation of captive reinsurance company or sponsored captive insurance company - Organization as reciprocal insurer - Branch captive insurance company - Considerations for issuance of license - Privileges and obligations.

A. A captive insurance company may be incorporated as a stock corporation or as a nonstock corporation, or may be formed as a limited liability company, partnership, limited partnership, statutory trust or any lawful form approved by the Insurance Commissioner.

B. An association captive insurance company, industrial insured captive insurance company or special purpose captive insurance company may be organized as a reciprocal insurer.

C. The Commissioner shall not issue the initial license or review the license of any captive insurer unless the Commissioner determines the following matters serve the best interest of the prospective policyholders and promote the general good of the state:

1. The character, reputation, financial standing, and purposes of the principals, owners or other persons who will direct or control the affairs of the captive insurer;

2. The character, reputation, financial responsibility, insurance experience, and business qualifications of the officers and directors; and

3. Other aspects as the Insurance Commissioner considers advisable.

D. In the case of a captive insurance company licensed as a branch captive insurance company, the findings required in subsection C above shall be in respect to the alien captive insurance company.

E. 1. A captive insurance company formed under the laws of this state or under the laws of another jurisdiction that is licensed under the provisions of this title shall have the privileges and be subject to the provisions of the laws of this state or the laws of such other jurisdiction, as applicable, under which such captive insurance company is organized as well as the applicable provisions contained in this title. In the event of conflict between the provisions of the laws of this state or the laws of such other jurisdiction, as applicable, under which such captive insurance company is organized, and the provisions of this title, the latter shall control.

2. A captive insurance company, formed or licensed under the Oklahoma Captive Insurance Company Act, has the privileges and is subject to the provisions of Oklahoma law as well as the applicable provisions contained in the Oklahoma Captive Insurance Company Act. If a conflict occurs between a provision of the general law of Oklahoma and a provision of the Oklahoma Captive Insurance Company Act, the latter controls. No provision of the Oklahoma Insurance Code, other than those contained in this act or otherwise specifically referencing such companies, shall apply to captive insurance companies.

3. In addition to the applicability of law provided in this section, a captive insurance company operating as a risk retention group shall be subject to the provisions of the Oklahoma Risk Retention Act under Sections 6451 through 6468 of this title.

4. All preliminary reports or results, working papers, recorded information, orders, documents and copies of documents produced by, obtained by or disclosed to the Commissioner or any other person in the course of any merger, consolidation, conversion, mutualization and change of control made under this section are confidential and are not subject to subpoena and may not be made public by the Commissioner or any employee or agent of the Commissioner without the written consent of the company, except to the extent provided in this subsection. Nothing in this subsection prevents the Commissioner from using this information in furtherance of the regulatory authority of the Commissioner under the Oklahoma Captive Insurance Company Act. The Commissioner may grant access to this information to public officers having jurisdiction over the regulation of insurance in any other state or country, or to law enforcement officers of this state or any other state or agency of the federal government at any time, so long as the officers receiving the information agree in writing to use and retain it in any manner consistent with this section.

5. The terms and conditions set forth in Articles 18 and 19 of the Oklahoma Insurance Code pertaining to insurance supervision, conservatorship, rehabilitation, and receiverships apply in full to captive insurance companies including for this purpose individual

protected cells of sponsored captive insurance companies as provided in Section 6470.29 of this title.

6. Any insurer which holds a current license to transact the business of insurance under the laws of any other jurisdiction may become an Oklahoma domiciled captive insurer by complying with all of the requirements of Oklahoma law relative to the organization and licensing of a captive insurer and obtaining the approval of the insurer's application for redomestication by the chief insurance regulatory official of the company's current and proposed domiciles. Added by Laws 2004, c. 334, § 17, emerg. eff. May 25, 2004. Amended by Laws 2013, c. 41, § 8, eff. Nov. 1, 2013; Laws 2015, c. 298, § 17, eff. Nov. 1, 2015; Laws 2018, c. 306, § 3; Laws 2021, c. 314, § 17, eff. Nov. 1, 2021; Laws 2022, c. 127, § 3, eff. Nov. 1, 2022.

§36-6470.10a. Establishment of series limited liability company.

Captive insurance companies formed or licensed under the Oklahoma Captive Insurance Company Act may establish a series limited liability company under the Oklahoma Limited Liability Company Act. Any exclusion of the business of a domestic insurer under Title 18 of the Oklahoma Statutes shall not apply to captive insurance companies formed or licensed under the Oklahoma Captive Insurance Company Act.

Added by Laws 2022, c. 127, § 4, eff. Nov. 1, 2022.

§36-6470.11. Reports - Waiver.

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 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 Section 6470.6 of this title, a captive insurance company shall report using generally accepted accounting principles, unless the Insurance Commissioner approves the use of statutory accounting principles or international accounting standards, 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.

1. The use of generally accepted accounting principles and the Insurance Department requires modifications, assets and liabilities to be reported as follows:

- a. letters of credit provided as capital funds pursuant to Section 6470 of this title are an asset for purposes of annual financial statement filings and shall be reported at their face value, and

- b. surplus notes issued pursuant to Section 2125 of this title shall be reported as surplus items in the capital section rather than as a liability.

2. Any captive insurance company whose use of statutory accounting principles is approved by the Commissioner may make such modifications and adaptations thereof as are necessary:

- a. to record, as "admitted", the full value of all investments by such captive insurance company permitted under this chapter, and
- b. subject to the Commissioner's approval, to make its reports under this section consistent with the purposes of this chapter.

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.

Added by Laws 2004, c. 334, § 18, emerg. eff. May 25, 2004. Amended by Laws 2009, c. 176, § 49, eff. Nov. 1, 2009; Laws 2013, c. 41, § 9, eff. Nov. 1, 2013; Laws 2021, c. 314, § 18, eff. Nov. 1, 2021.

§36-6470.12. Discounting of loss and loss adjustment expense reserves - Actuarial opinion.

A. Upon written application, accompanied by such information as the Commissioner requires, the Insurance Commissioner may grant permission to a sponsored captive insurance company or a special purpose captive insurance company to discount loss and loss adjustment expense reserves at treasury rates applied to the

applicable payments projected through the use of the expected payment pattern associated with the reserves.

B. A sponsored captive insurance company and a special purpose captive insurance company, and any captive insurer, at the Commissioner's discretion, shall file annually an actuarial opinion on the company's loss and loss adjustment expense reserves or life and health policy and claim reserves, as applicable. The individual who prepares the Statement of Actuarial Opinion must be independent of the captive company and its affiliates.

C. The Insurance Commissioner may disallow the discounting of reserves if a captive insurance company violates a provision of this title.

Added by Laws 2004, c. 334, § 19, emerg. eff. May 25, 2004. Amended by Laws 2013, c. 41, § 10, eff. Nov. 1, 2013; Laws 2015, c. 298, § 18, eff. Nov. 1, 2015; Laws 2018, c. 95, § 11, eff. Nov. 1, 2018.

§36-6470.13. Examination by Insurance Commissioner - Confidentiality - Application.

A. At least once in five (5) years, and whenever the Insurance Commissioner determines it to be prudent, the Commissioner personally, or a competent person appointed by the Commissioner, shall conduct an examination under Sections 309.1 through 309.7 of this title, as well as determine whether the captive insurer has complied with the Oklahoma Captive Insurance Company Act. The Commissioner upon application, in his or her discretion, may enlarge the five-year period to seven (7) years. The expenses and charges of the examination must be paid in accordance with the payment provisions of Sections 309.1 through 309.7 of this title.

B. All examination reports, preliminary examination reports or results, working papers, recorded information, documents and copies of documents produced by, obtained by, or disclosed to the Commissioner or any other person in the course of an examination made under this section are confidential and are not subject to subpoena and may not be made public by the Commissioner or an employee or agent of the Commissioner without the written consent of the company, except to the extent provided in this subsection. Nothing in this subsection prevents the Commissioner from using this information in furtherance of the regulatory authority of the Commissioner under the Oklahoma Captive Insurance Company Act. The Commissioner may grant access to this information to public officers having jurisdiction over the regulation of insurance in any other state or country, or to law enforcement officers of this state or any other state or agency of the federal government at any time, so long as the officers receiving the information agree in writing to hold it in a manner consistent with this section.

C. 1. This section applies to all business written by a captive insurance company; however, the examination for a branch

captive insurance company must be of branch business and branch operations only, as long as the branch captive insurance company provides annually to the Commissioner a certificate of compliance, or its equivalent, issued by or filed with the licensing authority of the jurisdiction in which the branch captive insurance company is formed and demonstrates to the satisfaction of the Commissioner that it is operating in sound financial condition in accordance with all applicable laws and regulations of that jurisdiction.

2. As a condition of licensure, the alien captive insurance company shall grant authority to the Commissioner for examination of the affairs of the alien captive insurance company in the jurisdiction in which the alien captive insurance company is formed. Added by Laws 2004, c. 334, § 20, emerg. eff. May 25, 2004. Amended by Laws 2006, c. 264, § 66, eff. July 1, 2006; Laws 2013, c. 41, § 11, eff. Nov. 1, 2013.

§36-6470.14. Suspension or revocation of license.

A. The license of a captive insurance company to conduct an insurance business in this state may be suspended or revoked by the Insurance Commissioner for:

1. Insolvency or impairment of capital and surplus;
2. Failure to meet the requirements of Section 6470.6 of this title;
3. Refusal or failure to submit an annual report, as required by Section 6470.11 of this title, or any other report or statement required by law or by lawful order of the Commissioner;
4. Failure to comply with its own charter, bylaws, or other organizational document;
5. Failure to pay any tax or fee, or submit to examination or any legal obligation relative to an examination, as required by this section;
6. Refusal or failure to pay the cost of examination;
7. Use of methods that, although not otherwise specifically prohibited by law, nevertheless render its operation detrimental or its condition unsound with respect to the public or to its policyholders; or
8. Failure otherwise to comply with laws of this state.

B. If the Commissioner finds, upon examination, hearing, or other evidence, that a captive insurance company has committed any of the acts specified in subsection A of this section, the Commissioner may suspend or revoke such license if the Commissioner considers it in the best interest of the public and the policyholders of the captive insurance company.

C. In addition to or in lieu of any applicable revocation or suspension of the license of a captive insurer, the Commissioner may fine any captive insurer who violates any provision of the Oklahoma

Insurance Code a civil penalty of not more than Five Thousand Dollars (\$5,000.00) for each occurrence.

Added by Laws 2004, c. 334, § 21, emerg. eff. May 25, 2004. Amended by Laws 2006, c. 264, § 67, eff. July 1, 2006; Laws 2013, c. 41, § 12, eff. Nov. 1, 2013.

§36-6470.15. Investment requirements - Loans.

A. An association captive insurance company, a sponsored captive insurance company, and a risk retention group shall comply with the investment requirements contained in the Oklahoma Insurance Code. The Insurance Commissioner may approve the use of alternative investment requirements upon application by such captive insurance company.

B. Except as to unimpaired paid-in capital as provided in paragraph 7 of subsection A of Section 6470.6 of this title, a pure captive insurance company, a special purpose captive insurance company, a branch captive insurance company, a series captive insurance company, and an industrial insured captive insurance company are not subject to any restrictions on allowable investments contained in the Oklahoma Insurance Code; however, the Insurance Commissioner may prohibit or limit an investment that threatens the solvency or liquidity of the company.

C. Loans of minimum capital and surplus funds required by Section 6470.6 of this title are prohibited.

D. Subject to subsections A and B of this section and Section 6470.31 of this title, as applicable, a captive insurance company may own securities of or other interests in another captive insurance company, whether voting or nonvoting.

Added by Laws 2004, c. 334, § 22, emerg. eff. May 25, 2004. Amended by Laws 2013, c. 41, § 13, eff. Nov. 1, 2013; Laws 2015, c. 298, § 19, eff. Nov. 1, 2015; Laws 2022, c. 127, § 5, eff. Nov. 1, 2022.

§36-6470.16. Reinsurance on risks ceded by another insurer - Credit for reserves.

A captive insurance company may cede or assume reinsurance and take credit for reserves, as authorized for domestic insurers by the Oklahoma Insurance Code.

Added by Laws 2004, c. 334, § 23, emerg. eff. May 25, 2004. Amended by Laws 2013, c. 41, § 14, eff. Nov. 1, 2013; Laws 2015, c. 298, § 20, eff. Nov. 1, 2015.

§36-6470.17. Membership in rating organization.

A captive insurance company may not be required to join a rating organization.

Added by Laws 2004, c. 334, § 24, emerg. eff. May 25, 2004.

§36-6470.18. Membership in, contribution to, or benefit from plan, pool, association, or guaranty or insolvency fund.

A captive insurance company may not join or contribute financially to a plan, pool, association, or guaranty or insolvency fund in this state, and a captive insurance company, or its insured or its parent or any affiliated company or any member organization of its association, or in the case of a captive insurance company organized as a reciprocal insurer, a subscriber of the company, or in the case of a sponsored captive insurance company, a protected cell or participant in a protected cell may not receive a benefit from a plan, pool, association, or guaranty or insolvency fund for claims arising out of the operations of such captive insurance company.

Added by Laws 2004, c. 334, § 25, emerg. eff. May 25, 2004. Amended by Laws 2013, c. 41, § 15, eff. Nov. 1, 2013.

§36-6470.19. Captive insurance tax rates - Definitions.

A. Each captive insurance company, other than a sponsored captive insurance company, and each protected cell of a sponsored captive insurance company, shall pay to the Insurance Department, by March 1 of each year, a tax at the rate of two-tenths of one percent (0.2%) on the direct premiums collected or contracted for on policies or contracts of insurance written by the captive insurance company during the year ending December 31 next preceding, after deducting from the direct premiums subject to the tax the amounts paid to policyholders as return premiums which shall include dividends on unabsorbed premiums or premium deposits returned or credited to policyholders up to a maximum tax for such year of One Hundred Thousand Dollars (\$100,000.00); provided however, that no tax shall be due or payable as to consideration received for annuity contracts.

B. A captive insurance company, other than a sponsored captive insurance company, and each protected cell of a sponsored captive insurance company, shall pay to the Department, by March 1 of each year, a tax at the rate of one-tenth of one percent (0.1%) of assumed reinsurance premium. However, no reinsurance tax applies to premiums for risks or portions of risks which are subject to taxation on a direct basis pursuant to subsection A of this section. A premium tax is not payable in connection with the receipt of assets in exchange for the assumption of loss reserves and other liabilities of another insurer under common ownership and control if the transaction is part of a plan to discontinue the operations of the other insurer and if the intent of the parties to the transaction is to renew or maintain business with the captive insurance company.

C. A sponsored captive insurance company shall pay to the Department, by March 1 of each year, a tax on direct and assumed

premiums equal, in the aggregate, to the minimum tax provided in subsection D of this section.

D. Except as provided in this section for a series captive insurance company, if the aggregate taxes to be paid by a captive insurance company or a protected cell of a sponsored captive insurance company calculated under subsections A and B of this section amount to less than Five Thousand Dollars (\$5,000.00) in any year, the captive insurance company or protected cell shall pay a minimum tax of Five Thousand Dollars (\$5,000.00) for that year. However, in the calendar year in which a captive insurance company is first licensed, or the protected cell is approved by the Commissioner, the minimum tax will be prorated on a quarterly basis. For those licensed in the first quarter, the prorated minimum tax is Five Thousand Dollars (\$5,000.00). For those licensed in the second quarter, the prorated minimum tax is Three Thousand Seven Hundred Fifty Dollars (\$3,750.00). For those licensed in the third quarter, the prorated minimum tax is Two Thousand Five Hundred Dollars (\$2,500.00). For those licensed in the fourth quarter, the prorated minimum tax is One Thousand Two Hundred Fifty Dollars (\$1,250.00). In the calendar year in which a captive insurance company is first licensed or the protected cell is first approved by the Commissioner, if the aggregate taxes to be paid calculated under subsections A and B of this section amount to less than the minimum tax prorated on a quarterly basis, the captive or protected cell shall pay the prorated minimum tax for that calendar year. Each series captive insurance company shall pay an annual minimum aggregate tax of Three Thousand Five Hundred Dollars (\$3,500.00). The aggregation of the tax paid by more than one series captive insurance company formed within a limited liability company or statutory trust or the corresponding law of another state shall not be restricted by the annual maximum premium tax limitations specified in subsections A and B of this section.

E. Subject to subsections F, G and H of this section, if the aggregate taxes on direct and assumed premiums to be paid by a captive insurance company or a protected cell of a sponsored captive insurance company calculated under subsections A and B of this section amount to more than One Hundred Thousand Dollars (\$100,000.00) in any year, the captive insurance company, protected cell of a sponsored captive insurance company or a series captive insurance company shall pay a maximum tax of One Hundred Thousand Dollars (\$100,000.00) for that year.

F. Two or more captive insurance companies under common ownership and control must be taxed as though they were a single captive insurance company. Two or more protected cells of a sponsored captive insurance company that are related by common ownership and control must be taxed as though they were a single protected cell.

G. As used in this section, "common ownership and control" means the direct or indirect ownership of eighty percent (80%) or more of the outstanding voting stock or other voting interests of two or more captive insurance companies or protected cells of a sponsored captive insurance company by the same person or persons.

H. A captive insurance company that has employed twenty-five or more separate qualified individuals throughout a given tax year and that otherwise would be liable under this section for tax for such year in an amount exceeding Fifty Thousand Dollars (\$50,000.00) shall pay to the Insurance Commissioner under this section a tax for such year in the amount of Fifty Thousand Dollars (\$50,000.00). For purposes of this subsection, "qualified individual" means a natural person employed in this state on a regular basis of thirty-five (35) or more hours per week either by such captive insurance company, or by a wholly-owned subsidiary of such captive insurance company that provides captive insurance company management, operating, investment or related services exclusively to such captive insurance company.

I. The tax provided for in this section constitutes all taxes collectible under the laws of this state from a captive insurance company or a protected cell of a sponsored captive insurance company, and no other occupation tax or other taxes may be levied or collected from a captive insurance company by the state or a county, city, or municipality within this state, except ad valorem taxes on real and personal property used in the production of income.

J. For the fiscal year beginning July 1, 2020, and for each fiscal year thereafter, the Insurance Commissioner shall report and disburse all fees and taxes collected pursuant to this section as follows:

1. Of the first Five Hundred Thousand Dollars (\$500,000.00):
 - a. thirty-six percent (36%) to the Oklahoma Firefighters Pension and Retirement Fund,
 - b. fourteen percent (14%) to the Oklahoma Police Pension and Retirement System,
 - c. five percent (5%) to the Law Enforcement Retirement Fund, and
 - d. forty-five percent (45%) to the State Treasury to the credit of the General Revenue Fund of the state;
2. Of the next Two Hundred Fifty Thousand Dollars (\$250,000.00), one hundred percent (100%) to the State Insurance Commissioner Revolving Fund to be used by the Department for the purposes of implementing and administering the Oklahoma Captive Insurance Company Act and any accompanying regulations; and
3. Of all amounts in excess of Seven Hundred Fifty Thousand Dollars (\$750,000.00):
 - a. thirty-six percent (36%) to the Oklahoma Firefighters Pension and Retirement Fund,

- b. fourteen percent (14%) to the Oklahoma Police Pension and Retirement System,
- c. five percent (5%) to the Law Enforcement Retirement Fund,
- d. fifteen percent (15%) to the State Treasury to the credit of the General Revenue Fund of the state, and
- e. thirty percent (30%) to the State Insurance Commissioner Revolving Fund to be used by the Department for the purposes of implementing and administering the Oklahoma Captive Insurance Company Act and any accompanying regulations.

Added by Laws 2004, c. 334, § 26, emerg. eff. May 25, 2004. Amended by Laws 2012, c. 365, § 6, emerg. eff. June 8, 2012; Laws 2013, c. 41, § 16, eff. Nov. 1, 2013; Laws 2015, c. 298, § 21, eff. Nov. 1, 2015; Laws 2020, c. 55, § 1, eff. July 1, 2020; Laws 2021, c. 314, § 19, eff. Nov. 1, 2021.

§36-6470.20. Sanctions.

A captive insurance company failing to make returns or to pay all taxes required by this section is subject to sanctions provided in the Oklahoma Insurance Code.

Added by Laws 2004, c. 334, § 27, emerg. eff. May 25, 2004. Amended by Laws 2013, c. 41, § 17, eff. Nov. 1, 2013; Laws 2015, c. 298, § 22, eff. Nov. 1, 2015.

§36-6470.21. Rules.

The Insurance Commissioner may promulgate and, from time to time, amend rules and issue orders relating to captive insurance companies as are necessary to enable the Insurance Commissioner to carry out the provisions of the Oklahoma Captive Insurance Company Act.

Added by Laws 2004, c. 334, § 28, emerg. eff. May 25, 2004.

§36-6470.22. Exemptions for special purpose captive insurance companies.

The Insurance Commissioner may, by rule, regulation, or order, exempt special purpose captive insurance companies, on a case-by-case basis, from provisions of the Oklahoma Insurance Code, Oklahoma Captive Insurance Company Act and any rule or regulation established under either that he or she determines to be inappropriate to apply to such companies given the nature of the risks to be insured.

Added by Laws 2004, c. 334, § 29, emerg. eff. May 25, 2004. Amended by Laws 2013, c. 41, § 18, eff. Nov. 1, 2013.

§36-6470.23. Repealed by Laws 2015, c. 298, § 30, eff. Nov. 1, 2015.

§36-6470.24. Repealed by Laws 2009, c. 432, § 28, eff. July 1, 2009.

§36-6470.24.1. Notice requirements.

No captive insurance company shall voluntarily take any of the following actions without providing the Insurance Commissioner at least thirty (30) days prior written notice and receiving the Commissioner's approval of any such action:

1. The dissolution of the captive insurance company;
2. A sale, exchange, lease, mortgage, assignment, pledge or other transfer of or granting of a security interest in, all or substantially all of the assets of the captive insurance company;
3. Incurring a material indebtedness by the captive insurance company;
4. Any making of a material loan or other material extension of credit by the captive insurance company;
5. Any material payment out of capital and surplus;
6. Any merger or consolidation to which the captive insurance company is a constituent party;
7. Any conversion of the captive insurance company to another business form;
8. Any transfer to or domestication in any jurisdiction by the captive insurance company; or
9. Any amendment of the organizational documents of the captive insurance company.

For purposes of this section, "material", in relation to financial matters, means any transaction or series of related transactions involving more than the lesser of five percent (5%) of the captive insurance company's assets or twenty-five percent (25%) of its capital and surplus. "Assets" and "capital and surplus" shall be measured as of the most recent filed report required by Section 6470.11 of Title 36 of the Oklahoma Statutes.

Added by Laws 2013, c. 41, § 1, eff. Nov. 1, 2013.

§36-6470.24.2. Inspection and preservation of records.

A. Unless otherwise approved by the Commissioner, a captive insurance company formed under the provisions of this act shall maintain its books, records, documents, accounts, vouchers and agreements in this state.

A captive insurance company shall make its books, records, documents, accounts, vouchers and agreements available for inspection by the Commissioner at any time. A captive insurance company shall keep its books, records, documents, accounts, vouchers and agreements in such manner that its financial condition, affairs and operations can be readily ascertained and in such manner that the Commissioner may readily verify its financial statements and determine its compliance with this act.

B. Unless otherwise approved by the Commissioner, all original books, records, documents, accounts, vouchers and agreements of a captive insurance company formed under the provisions of this act must be preserved and kept available in this state for the purpose of examination and inspection until the Commissioner approves the destruction or other disposition of the books, records, documents, accounts, vouchers and agreements. If the Commissioner approves the preservation and keeping of the foregoing outside this state, the captive insurance company shall maintain a complete and true copy of each such original in the state. Books, records, documents, accounts, vouchers and agreements may be photographed, reproduced on film or stored and reproduced electronically.
Added by Laws 2013, c. 41, § 2, eff. Nov. 1, 2013.

§36-6470.25. Protected cell - Use of assets.

In the case of a sponsored captive insurance company:

1. The assets of the protected cell may not be used to pay expenses or claims other than those attributable to the protected cell; and

2. Its capital and surplus at all times must be available to pay expenses of or claims against the sponsored captive insurance company and may not be used to pay expenses or claims attributable to a protected cell.

Added by Laws 2004, c. 334, § 32, emerg. eff. May 25, 2004. Amended by Laws 2006, c. 264, § 69, eff. July 1, 2006; Laws 2015, c. 298, § 23, eff. Nov. 1, 2015.

§36-6470.26. Repealed by Laws 2013, c. 41, § 24, eff. Nov. 1, 2013.

§36-6470.27. Standards ensuring exercise of control of risk management function of insured controlled unaffiliated business - Regulations.

The Insurance Commissioner shall promulgate regulations establishing standards to ensure that a parent or affiliated company is able to exercise control of the risk management for any controlled unaffiliated business to be insured by a pure captive insurance company; however, until such time as these regulations are promulgated, the Insurance Commissioner may by temporary order grant authority to a pure captive insurance company to insure risks.

Added by Laws 2004, c. 334, § 34, emerg. eff. May 25, 2004. Amended by Laws 2013, c. 41, § 19, eff. Nov. 1, 2013; Laws 2015, c. 298, § 24, eff. Nov. 1, 2015.

§36-6470.28. Acquisition of control.

The provisions of Article 16A of the Insurance Code applicable to acquisition of control or merger with a domestic insurer shall apply to acquisition of control of an association captive insurance

company, sponsored captive insurance company, special purpose captive insurance company, or industrial insured captive insurance company formed or licensed under the Oklahoma Captive Insurance Company Act.

Added by Laws 2004, c. 334, § 35, emerg. eff. May 25, 2004. Amended by Laws 2013, c. 41, § 20, eff. Nov. 1, 2013.

§36-6470.29. Sponsored captive insurance company - Supplemental materials - Protected cells.

A. In addition to the provisions of Sections 6470.1 through 6470.28 of this title and the provisions of Sections 6470.29 through 6470.31 of this title shall apply to sponsored captive insurance companies, and the provisions of Section 6470.24.1 of this title shall apply to each protected cell of a sponsored captive insurance company.

B. Supplemental license application materials.

In addition to the information required by subsection C of Section 6470.3 of this title, each applicant sponsored captive insurance company shall file with the Commissioner the following:

1. Materials demonstrating to the satisfaction of the Commissioner how the applicant will report to the Commissioner on, and account for, the loss and expense experience of each protected cell;

2. A statement acknowledging that all financial records of the sponsored captive insurance company, including records pertaining to any protected cells, shall be made available for inspection or examination by the Commissioner or the Commissioner's designated agent;

3. All contracts or sample contracts between the sponsored captive insurance company and any participants; and

4. Evidence that expenses shall be allocated to each protected cell in a fair and equitable manner.

C. One or more sponsors may form a sponsored captive insurance company under the Oklahoma Captive Insurance Company Act.

D. A sponsored captive insurance company formed or licensed under the Oklahoma Captive Insurance Company Act may establish and maintain one or more protected cells to insure risks of one or more participants, subject to the following conditions:

1. The persons holding the voting interests of a sponsored captive insurance company must be limited to its participants and sponsors; provided, that a sponsored captive insurance company may issue nonvoting securities or interests to other persons on terms approved by the Commissioner;

2. Each protected cell must be accounted for separately on the books and records of the sponsored captive insurance company to reflect the financial condition and results of operations of the protected cell, net income or loss, dividends or other distributions

to participants, and other factors may be provided in the participant contract or required by the Insurance Commissioner;

3. The assets of a protected cell must not be chargeable with liabilities of any other protected cell or, unless otherwise agreed in the applicable participant contract, of the sponsored captive insurance company;

4. No sale, exchange, or other transfer of assets, or dividend or other distribution, may be made with respect to a protected cell by the sponsored captive insurance company without the consent of the participants of each affected protected cell;

5. No sale, exchange, transfer of assets, dividend, or distribution, other than a payment to a sponsor in accordance with the applicable participant contract, may be made from a protected cell to a sponsor or participant without the approval of the Insurance Commissioner and in no event may the approval be given if the sale, exchange, transfer, dividend, or distribution would result in insolvency or impairment with respect to a protected cell;

6. A sponsored captive insurance company annually shall file with the Insurance Commissioner financial reports the Insurance Commissioner requires, which shall include, but are not limited to, accounting statements detailing the financial experience of each protected cell;

7. A sponsored captive insurance company shall notify the Insurance Commissioner in writing within ten (10) business days of a protected cell that is insolvent or otherwise unable to meet its claim or expense obligations; and

8. No participant contract shall take effect without the prior written approval of the Insurance Commissioner, and the addition of each new protected cell and withdrawal of any participant or termination of any existing protected cell constitutes a change in the business plan of the sponsored captive insurance company requiring the prior written approval of the Insurance Commissioner. Added by Laws 2004, c. 334, § 36, emerg. eff. May 25, 2004. Amended by Laws 2013, c. 41, § 21, eff. Nov. 1, 2013; Laws 2015, c. 298, § 25, eff. Nov. 1, 2015.

§36-6470.30. Sponsor of sponsored captive insurance company.

A sponsor of a sponsored captive insurance company must be an insurer licensed pursuant to the laws of a state, an insurance holding company that controls an insurer licensed pursuant to the laws of any state and subject to registration pursuant to the insurance holding company system laws of the state of domicile of the insurer, a reinsurer authorized or approved pursuant to the laws of a state, or a captive insurance company formed or licensed pursuant to the Oklahoma Captive Insurance Company Act, a holding company, a trust, an individual or other organization as permitted by the Insurance Commissioner. A risk retention group may be a

participant of a sponsored captive insurance company only to the extent that it is the sole participant of one or more protected cells.

Added by Laws 2004, c. 334, § 37, emerg. eff. May 25, 2004. Amended by Laws 2013, c. 41, § 22, eff. Nov. 1, 2013; Laws 2015, c. 298, § 26, eff. Nov. 1, 2015.

§36-6470.30.1. Requirements for writing business.

The business written by a sponsored captive insurance company with respect to each protected cell must be:

1. Fronted by an insurance company licensed pursuant to the laws of any state or any jurisdiction if the insurance company is a wholly owned subsidiary of an insurance company licensed pursuant to the laws of any state;

2. Reinsured by a reinsurer authorized or approved by this state; or

3. Secured by a trust fund in the United States for the benefit of policyholders and claimants or funded by an irrevocable letter of credit or other asset acceptable to the Insurance Commissioner. The amount of security provided may not be less than the reserves associated with those liabilities, not fronted or reinsured, including reserves for losses, allocated loss adjustment expenses, incurred but unreported losses, and unearned premiums for business written through the protected cell of the participant. The Insurance Commissioner may require the sponsored captive to increase the funding of any security arrangement established pursuant to this subsection. If the form of security is a letter of credit, the letter of credit must be established, issued, or confirmed by a financial institution chartered in this state, a member of the federal reserve system, or a bank chartered by another state if that state-chartered bank is acceptable to the Insurance Commissioner. A trust and trust instrument maintained pursuant to this item must be in a form and upon terms approved by the Insurance Commissioner.

Added by Laws 2013, c. 41, § 3, eff. Nov. 1, 2013.

§36-6470.31. Participants in sponsored captive insurance company.

A. An association, a corporation, a limited liability company, a partnership, a trust, or other business entity may be a participant in a sponsored captive insurance company formed or licensed pursuant to the Oklahoma Captive Insurance Company Act.

B. A sponsor may be a participant in a sponsored captive insurance company.

C. A participant need not be an owner of the sponsored captive insurance company or an affiliate of the company.

D. Unless otherwise approved by the Insurance Commissioner, a participant may insure through a sponsored captive insurance company

only its own risks or the risks of its affiliates who are participants.

Added by Laws 2004, c. 334, § 38, emerg. eff. May 25, 2004. Amended by Laws 2013, c. 41, § 23, eff. Nov. 1, 2013.

§36-6470.31.1. Combination of assets.

Notwithstanding the provisions of paragraph 2 of subsection B of Section 6470.29 of Title 36 of the Oklahoma Statutes, a sponsored captive insurance company may combine the assets of two or more protected cells for purposes of investing those assets. Such a combination of assets may not be construed as defeating the segregation of assets required by this act, or for accounting or other purposes.

Added by Laws 2013, c. 41, § 4, eff. Nov. 1, 2013.

§36-6470.32. Repealed by Laws 2013, c. 41, § 24, eff. Nov. 1, 2013.

§36-6470.33. Repealed by Laws 2013, c. 41, § 24, eff. Nov. 1, 2013.

§36-6470.34. Entity-protected cell.

A. A protected cell of a sponsored captive insurance company may be formed as an entity-protected cell. "Entity-protected cell" means a protected cell that is established as any type of legal entity separate from the sponsored captive insurance company of which it is a part.

B. Subject to the prior written approval of the sponsored captive insurance company and of the Insurance Commissioner, an entity-protected cell shall be entitled to enter into contracts and undertake obligations in its own name and for its own account. In the case of a contract or obligation to which the sponsored captive insurance company is not a party, either in its own name and for its own account or on behalf of a protected cell, the counterparty to the contract or obligation shall have no right or recourse against the sponsored captive insurance company and its assets other than against assets properly attributable to the entity-protected cell that is a party to the contract or obligation.

C. The articles of incorporation or articles of organization of an entity-protected cell shall refer to the sponsored captive insurance company for which it is a protected cell and shall state that the protected cell is incorporated or organized for the limited purposes authorized by the sponsored captive insurance company's license. A copy of the prior written approval of the Commissioner to add the entity-protected cell, required by Section 6470.29 of Title 36 of the Oklahoma Statutes, shall be attached to and filed with the articles of incorporation or the articles of organization.

D. Sponsored captive insurance companies, including those licensed as special purpose captive insurance companies, shall have

the option to establish one or more protected cells as a separate corporation, mutual corporation, nonprofit corporation, limited liability company, or reciprocal insurer. This section shall not be construed to limit any rights or protections applicable to protected cells not established as corporations, mutual corporations, nonprofit corporations, limited liability companies, or reciprocal insurers.

Added by Laws 2015, c. 298, § 27, eff. Nov. 1, 2015.

§36-6470.35. Dormant captive insurance company - Certificate of dormancy.

A. As used in this section, "dormant captive insurance company" means a captive insurance company that has:

1. Ceased transacting the business of insurance including the issuance of insurance policies; and
2. No remaining liabilities associated with insurance business transactions or insurance policies issued prior to the filing of its application for a certificate of dormancy under this section.

B. A dormant captive insurance company domiciled in this state that meets the criteria of subsection A of this section may apply to the Insurance Commissioner for a certificate of dormancy. The certificate of dormancy shall be subject to renewal every five (5) years and shall be forfeited if not renewed within such time.

C. A dormant captive insurance company that has been issued a certificate of dormancy shall:

1. Possess and thereafter maintain unimpaired, paid-in capital and surplus of not less than Twenty-five Thousand Dollars (\$25,000.00);
2. Submit on or before March 1 of each year to the Insurance Commissioner a report of its financial condition, verified by an oath of two of its executive officers, in a form prescribed by the Insurance Commissioner; and
3. Pay a nonrefundable annual fee of Five Hundred Dollars (\$500.00).

D. A dormant captive insurance company shall not be subject to or liable for the payment of any tax under Section 6470 of this title for the initial five-year dormancy.

E. A dormant captive insurance company shall apply to the Insurance Commissioner for approval to surrender its certificate of dormancy and resume conducting the business of insurance prior to issuing any insurance policies.

F. A certificate of dormancy shall be revoked if a dormant captive insurance company no longer meets the criteria of subsection A of this section.

G. A dormant captive insurance company may be subject to examination under Section 6470.13 of this title for any year when it did not qualify as a dormant captive insurance company. The

Insurance Commissioner may examine a dormant captive insurance company pursuant to Section 6470.13 of this title.

H. The Insurance Commissioner may promulgate and adopt rules and regulations implementing the provisions of this section.

Added by Laws 2021, c. 478, § 33, emerg. eff. May 12, 2021. Amended by Laws 2022, c. 154, § 10, eff. Nov. 1, 2022.

§36-6475.1. Uniform Health Carrier External Review Act.

Sections 6475.1 through 6475.17 of this title shall be known and may be cited as the "Uniform Health Carrier External Review Act".

Added by Laws 2011, c. 278, § 35. Amended by Laws 2011, c. 360, § 25; Laws 2022, c. 154, § 11, eff. Nov. 1, 2022.

§36-6475.2. Purpose.

The purpose of the Uniform Health Carrier External Review Act is to provide uniform standards for the establishment and maintenance of external review procedures to assure that covered persons have the opportunity for an independent review of an adverse determination or final adverse determination, as defined in this act.

Added by Laws 2011, c. 278, § 36 and Laws 2011, c. 360, § 26.

NOTE: Laws 2011, c. 278, § 36 and Laws 2011, c. 360, § 26 added identical sections under the same number.

§36-6475.3. Definitions.

For purposes of the Uniform Health Carrier External Review Act:

1. "Adverse determination" means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated;

2. "Ambulatory review" means utilization review of health care services performed or provided in an outpatient setting;

3. "Authorized representative" means:

- a. a person to whom a covered person has given express written consent to represent the covered person in an external review,
- b. a person authorized by law to provide substituted consent for a covered person, or
- c. a family member of the covered person or the covered person's treating health care professional only when the covered person is unable to provide consent;

4. "Best evidence" means evidence based on:

- a. randomized clinical trials,
- b. if randomized clinical trials are not available, cohort studies or case-control studies,
- c. if subparagraphs a and b of this paragraph are not available, case-series, or
- d. if subparagraphs a, b and c of this paragraph are not available, expert opinion;

5. "Case-control study" means a retrospective evaluation of two groups of patients with different outcomes to determine which specific interventions the patients received;

6. "Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions;

7. "Case-series" means an evaluation of a series of patients with a particular outcome, without the use of a control group;

8. "Certification" means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness;

9. "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by a health carrier to determine the necessity and appropriateness of health care services;

10. "Cohort study" means a prospective evaluation of two groups of patients with only one group of patients receiving a specific intervention or specific interventions;

11. "Commissioner" means the Insurance Commissioner;

12. "Concurrent review" means utilization review conducted during a hospital stay or course of treatment of a patient;

13. "Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan;

14. "Covered person" means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan;

15. "Discharge planning" means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility;

16. "Disclose" means to release, transfer or otherwise divulge protected health information to any person other than the individual who is the subject of the protected health information;

17. "Emergency medical condition" means the sudden and, at the time, unexpected onset of a health condition or illness that requires immediate medical attention, where failure to provide

medical attention would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy;

18. "Emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition;

19. "Evidence-based standard" means the conscientious, explicit and judicious use of the current best evidence based on the overall systematic review of the research in making decisions about the care of individual patients;

20. "Expert opinion" means a belief or an interpretation by specialists with experience in a specific area about the scientific evidence pertaining to a particular service, intervention or therapy;

21. "Facility" means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings;

22. "Final adverse determination" means an adverse determination involving a covered benefit that has been upheld by a health carrier, or its designee utilization review organization, at the completion of the health carrier's internal grievance process procedures;

23. "Health benefit plan" means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services;

24. "Health care professional" means a physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law;

25. "Health care provider" or "provider" means a health care professional or a facility;

26. "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease;

27. "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the Commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including but not limited to a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health care services;

28. "Health information" means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relate to:

- a. the past, present or future physical, mental, or behavioral health or condition of an individual or a member of the individual's family,
- b. the provision of health care services to an individual, or
- c. payment for the provision of health care services to an individual;

29. "Independent review organization" means an entity that conducts independent external reviews of adverse determinations and final adverse determinations;

30. "Medical or scientific evidence" means evidence found in the following sources:

- a. peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of the published articles for review by experts who are not part of the editorial staff,
- b. peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medicus (EMBASE),
- c. medical journals recognized by the Secretary of Health and Human Services under Section 1861(t)(2) of the federal Social Security Act,
- d. the following standard reference compendia:
 - (1) the American Hospital Formulary Service-Drug Information,
 - (2) Drug Facts and Comparisons,
 - (3) the American Dental Association Accepted Dental Therapeutics, and
 - (4) the United States Pharmacopoeia-Drug Information,
- e. findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including but not limited to:
 - (1) the federal Agency for Healthcare Research and Quality,
 - (2) the National Institutes of Health,
 - (3) the National Cancer Institute,

- (4) the National Academy of Sciences,
- (5) the Centers for Medicare and Medicaid Services,
- (6) the federal Food and Drug Administration, and
- (7) any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services, or

f. any other medical or scientific evidence that is comparable to the sources listed in subparagraphs a through e of this paragraph;

31. "NAIC" means the National Association of Insurance Commissioners;

32. "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing;

33. "Prospective review" means utilization review conducted prior to an admission or a course of treatment;

34. "Protected health information" means health information:

- a. that identifies an individual who is the subject of the information, or
- b. with respect to which there is a reasonable basis to believe that the information could be used to identify an individual;

35. "Randomized clinical trial" means a controlled, prospective study of patients that have been randomized into an experimental group and a control group at the beginning of the study with only the experimental group of patients receiving a specific intervention, which includes study of the groups for variables and anticipated outcomes over time;

36. "Retrospective review" means a review of medical necessity conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment;

37. "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health care service to assess the clinical necessity and appropriateness of the initial proposed health care service;

38. "Utilization review" means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include but are not limited to ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review; and

39. "Utilization review organization" means an entity that conducts utilization review, other than a health carrier performing a review for its own health benefit plans.

Added by Laws 2011, c. 278, § 37 and Laws 2011, c. 360, § 27.

NOTE: Laws 2011, c. 278, § 37 and Laws 2011, c. 360, § 27 added identical sections under the same number.

§36-6475.4. Applicability of act.

A. Except as provided in subsection B of this section, the Uniform Health Carrier External Review Act shall apply to all health carriers.

B. The provisions of the Uniform Health Carrier External Review Act shall not apply to a policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance, as defined in Section 4424 of Title 36 of the Oklahoma Statutes, vision care or any other limited supplemental benefit or to a Medicare supplement policy of insurance, as defined in Section 3611.1 of Title 36 of the Oklahoma Statutes, coverage under a plan through Medicare, Medicaid, or the federal employees health benefits program, any coverage issued under Chapter 55 of Title 10, U.S. Code and any coverage issued as supplement to that coverage, any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis.

Added by Laws 2011, c. 278, § 38 and Laws 2011, c. 360, § 28.

NOTE: Laws 2011, c. 278, § 38 and Laws 2011, c. 360, § 28 added identical sections under the same number.

§36-6475.5. External review.

A. 1. A health carrier shall notify the covered person in writing of the covered person's right to request an external review to be conducted pursuant to Section 6475.8, 6475.9, or 6475.10 of this title and include the appropriate statements and information set forth in subsection B of this section at the same time the health carrier sends written notice of:

- a. an adverse determination upon completion of the health carrier's utilization review process set forth in Sections 6551 through 6565 of this title, and
- b. a final adverse determination.

2. As part of the written notice required under paragraph 1 of this subsection, a health carrier shall include the following, or substantially equivalent, language: "We have denied your request for the provision of or payment for a health care service or course of treatment. You may have the right to have our decision reviewed

by health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested by submitting a request for external review to the Oklahoma Insurance Department."

3. The Insurance Commissioner may promulgate any necessary rule providing for the form and content of the notice required under this section.

B. 1. The health carrier shall include in the notice required under subsection A of this section:

a. for a notice related to an adverse determination, a statement informing the covered person that:

- (1) if the covered person has a medical condition where the time frame for completion of an expedited review of a grievance involving an adverse determination would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may file a request for an expedited external review to be conducted pursuant to Section 6475.10 of this title, or Section 6475.11 of this title if the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the adverse determination would be significantly less effective if not promptly initiated, at the same time the covered person or the covered person's authorized representative files a request for an expedited review of a grievance involving an adverse determination, but that the independent review organization assigned to conduct the expedited external review will determine whether the covered person shall be required to complete the expedited review of the grievance prior to conducting the expedited external review, and
- (2) the covered person or the covered person's authorized representative may file a grievance under the health carrier's internal grievance process, but if the health carrier has not issued a written decision to the covered person or the

covered person's authorized representative within thirty (30) days following the date the covered person or the covered person's authorized representative files the grievance with the health carrier and the covered person or the covered person's authorized representative has not requested or agreed to a delay, the covered person or the covered person's authorized representative may file a request for external review pursuant to Section 6475.6 of this title and shall be considered to have exhausted the health carrier's internal grievance process for purposes of Section 6475.7 of this title, and

- b. for a notice related to a final adverse determination, a statement informing the covered person that:
 - (1) if the covered person has a medical condition where the time frame for completion of a standard external review pursuant to Section 6475.8 of this title would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may file a request for an expedited external review pursuant to Section 6475.9 of this title, or
 - (2) if the final adverse determination concerns:
 - (a) an admission, availability of care, continued stay or health care service for which the covered person received emergency services, but has not been discharged from a facility, the covered person or the covered person's authorized representative may request an expedited external review pursuant to Section 6475.9 of this title, or
 - (b) a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational, the covered person or the covered person's authorized representative may file a request for a standard external review to be conducted pursuant to Section 6475.10 of this title or if the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the request would be significantly less

effective if not promptly initiated, the covered person or the covered person's authorized representative may request an expedited external review to be conducted under Section 6475.10 of this title.

2. In addition to the information to be provided pursuant to paragraph 1 of this subsection, the health carrier shall include a copy of the description of both the standard and expedited external review procedures the health carrier is required to provide pursuant to Section 6475.17 of this title, highlighting the provisions in the external review procedures that give the covered person or the covered person's authorized representative the opportunity to submit additional information and including any forms used to process an external review.

3. As part of any forms provided under paragraph 2 of this subsection, the health carrier shall include an authorization form, or other document approved by the Commissioner that complies with the requirements of 45 CFR, Section 164.508, by which the covered person, for purposes of conducting an external review under this act, authorizes the health carrier and the covered person's treating health care provider to disclose protected health information including medical records, concerning the covered person that are pertinent to the external review.

Added by Laws 2011, c. 278, § 39. Amended by Laws 2011, c. 360, § 29; Laws 2022, c. 154, § 12, eff. Nov. 1, 2022.

§36-6475.6. Form of external review requests.

A. 1. Except for a request for an expedited external review as set forth in Section 6475.9 of this title, all requests for external review shall be made in writing to the Insurance Commissioner.

2. The Commissioner may prescribe by rule the form and content of external review requests required to be submitted under this section.

B. A covered person or the covered person's authorized representative may make a request for an external review of an adverse determination or final adverse determination.

Added by Laws 2011, c. 278, § 40. Amended by Laws 2011, c. 360, § 30; Laws 2022, c. 154, § 13, eff. Nov. 1, 2022.

§36-6475.7. External review procedure.

A. 1. Except as provided in subsection B of this section, a request for an external review pursuant to Section 6475.8, 6475.9, or 6475.10 of this title shall not be made until the covered person has exhausted the health carrier's internal grievance process.

2. A covered person shall be considered to have exhausted the health carrier's internal grievance process for purposes of this

section, if the covered person or the covered person's authorized representative:

- a. has filed a grievance involving an adverse determination, and
- b. except to the extent the covered person or the covered person's authorized representative requested or agreed to a delay, has not received a written decision on the grievance from the health carrier within thirty (30) days following the date the covered person or the covered person's authorized representative filed the grievance with the health carrier.

3. Notwithstanding paragraph 2 of this subsection, a covered person or the covered person's authorized representative may not make a request for an external review of an adverse determination involving a retrospective review determination made pursuant to Sections 6551 through 6565 of this title until the covered person has exhausted the health carrier's internal grievance process.

B. 1. a. At the same time a covered person or the covered person's authorized representative files a request for an expedited review of a grievance involving an adverse determination, the covered person or the covered person's authorized representative may file a request for an expedited external review of the adverse determination:

- (1) under Section 6475.9 of this title if the covered person has a medical condition where the time frame for completion of an expedited review of the grievance involving an adverse determination would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, or
- (2) under Section 6475.10 of this title if the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the adverse determination would be significantly less effective if not promptly initiated.

b. Upon receipt of a request for an expedited external review under subparagraph a of this paragraph, the independent review organization conducting the external review in accordance with the provisions of

Section 6475.9 or 6475.10 of this title shall determine whether the covered person shall be required to complete the expedited review process before it conducts the expedited external review.

- c. Upon a determination made pursuant to subparagraph b of this paragraph that the covered person must first complete the expedited grievance review process, the independent review organization immediately shall notify the covered person and, if applicable, the covered person's authorized representative of this determination and that it will not proceed with the expedited external review set forth in Section 6475.9 of this title until completion of the expedited grievance review process and the covered person's grievance at the completion of the expedited grievance review process remains unresolved.

2. A request for an external review of an adverse determination may be made before the covered person has exhausted the health carrier's internal grievance procedures whenever the health carrier agrees to waive the exhaustion requirement.

C. If the requirement to exhaust the health carrier's internal grievance procedures is waived under paragraph 2 of subsection B of this section, the covered person or the covered person's authorized representative may file a request in writing for a standard external review as set forth in Section 6475.8 or 6475.10 of this title.

Added by Laws 2011, c. 278, § 41. Amended by Laws 2011, c. 360, § 31; Laws 2022, c. 154, § 14, eff. Nov. 1, 2022.

§36-6475.8. Receipt of request for external review.

A. 1. Within four (4) months after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to Section 6475.5 of this title, a covered person or the covered person's authorized representative may file a request for an external review with the Insurance Commissioner.

2. Within one (1) business day after the date of receipt of a request for external review pursuant to paragraph 1 of this subsection, the Commissioner shall send a copy of the request to the health carrier.

B. Within five (5) business days following the date of receipt of the copy of the external review request from the Commissioner under paragraph 2 of subsection A of this section, the health carrier shall complete a preliminary review of the request to determine whether:

1. The individual is or was a covered person in the health benefit plan at the time the health care service was requested or, in the case of a retrospective review, was a covered person in the

health benefit plan at the time the health care service was provided;

2. The health care service that is the subject of the adverse determination or the final adverse determination is a covered service under the covered person's health benefit plan, but for a determination by the health carrier that the health care service is not covered because it does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness;

3. The covered person has exhausted the health carrier's internal grievance process unless the covered person is not required to exhaust the health carrier's internal grievance process pursuant to Section 6475.7 of this title; and

4. The covered person has provided all the information and forms required to process an external review including the release form provided under subsection B of Section 6475.5 of this title.

C. 1. Within one (1) business day after completion of the preliminary review, the health carrier shall notify the Commissioner and covered person and, if applicable, the covered person's authorized representative in writing whether:

- a. the request is complete, and
- b. the request is eligible for external review.

2. If the request:

- a. is not complete, the health carrier shall inform the covered person and, if applicable, the covered person's authorized representative and the Commissioner in writing and include in the notice what information or materials are needed to make the request complete, or
- b. is not eligible for external review, the health carrier shall inform the covered person, if applicable, the covered person's authorized representative and the Commissioner in writing and include in the notice the reasons for its ineligibility.

3. a. The Commissioner may specify the form for the health carrier's notice of initial determination under this subsection and any supporting information to be included in the notice.

- b. The notice of initial determination shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that the external review request is ineligible for review may be appealed to the Commissioner.

4. a. The Commissioner may determine that a request is eligible for external review under subsection B of this section notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review.
- b. In making a determination under subparagraph a of this paragraph, the Commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of the Uniform Health Carrier External Review Act.

D. 1. Whenever the Commissioner receives a notice that a request is eligible for external review following the preliminary review conducted pursuant to subsection C of this section, within one (1) business day after the date of receipt of the notice, the Commissioner shall:

- a. assign an independent review organization from the list of approved independent review organizations compiled and maintained by the Commissioner pursuant to Section 6475.12 of this title to conduct the external review and notify the health carrier of the name of the assigned independent review organization, and
- b. notify in writing the covered person and, if applicable, the covered person's authorized representative of the request's eligibility and acceptance for external review.

2. In reaching a decision, the assigned independent review organization shall not be bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in Sections 6551 through 6555 of this title or the health carrier's internal grievance process.

3. The Commissioner shall include in the notice provided to the covered person and, if applicable, the covered person's authorized representative a statement that the covered person or the covered person's authorized representative may submit in writing to the assigned independent review organization within five (5) business days following the date of receipt of the notice provided pursuant to paragraph 1 of this subsection additional information that the independent review organization shall consider when conducting the external review. The independent review organization is not required to, but may, accept and consider additional information submitted after five (5) business days.

E. 1. Within five (5) business days after the date of receipt of the notice provided pursuant to paragraph 1 of subsection D of this section, the health carrier or its designee utilization review organization shall provide to the assigned independent review

organization the documents and any information considered in making the adverse determination or final adverse determination.

2. Except as provided in paragraph 3 of this subsection, failure by the health carrier or its utilization review organization to provide the documents and information within the time specified in paragraph 1 of this subsection shall not delay the conduct of the external review.

3. a. If the health carrier or its utilization review organization fails to provide the documents and information within the time specified in paragraph 1 of this subsection, the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

b. Within one (1) business day after making the decision under subparagraph a of this paragraph, the independent review organization shall notify the covered person, if applicable, the covered person's authorized representative, the health carrier, and the Commissioner.

F. 1. The assigned independent review organization shall review all of the information and documents received pursuant to subsection E of this section and any other information submitted in writing to the independent review organization by the covered person or the covered person's authorized representative pursuant to paragraph 3 of subsection D of this section.

2. Upon receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to paragraph 3 of subsection D of this section, the assigned independent review organization shall within one (1) business day forward the information to the health carrier.

G. 1. Upon receipt of the information, if any, required to be forwarded pursuant to paragraph 2 of subsection F of this section, the health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.

2. Reconsideration by the health carrier of its adverse determination or final adverse determination pursuant to paragraph 1 of this subsection shall not delay or terminate the external review.

3. The external review may only be terminated if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the health care service that is the subject of the adverse determination or final adverse determination.

4. a. Within one (1) business day after making the decision to reverse its adverse determination or final adverse determination, as provided in paragraph 3 of this subsection, the health carrier shall notify the

covered person, if applicable, the covered person's authorized representative, the assigned independent review organization, and the Commissioner in writing of its decision.

- b. The assigned independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to subparagraph a of this paragraph.

H. In addition to the documents and information provided pursuant to subsection E of this section, the assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

1. The covered person's medical records;
2. The attending health care professional's recommendation;
3. Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative, or the covered person's treating provider;
4. The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier;
5. The most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
6. Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization; and
7. The opinion of the independent review organization's clinical reviewer or reviewers after considering paragraphs 1 through 6 of this subsection to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

I. 1. Within forty-five (45) days after the date of receipt of the request for an external review, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination to:

- a. the covered person,
- b. if applicable, the covered person's authorized representative,
- c. the health carrier, and
- d. the Commissioner.

2. The independent review organization shall include in the notice sent pursuant to paragraph 1 of this subsection:

- a. a general description of the reason for the request for external review,
- b. the date the independent review organization received the assignment from the Commissioner to conduct the external review,
- c. the date the external review was conducted,
- d. the date of its decision,
- e. the principal reason or reasons for its decision including what applicable, if any, evidence-based standards were a basis for its decision,
- f. the rationale for its decision, and
- g. references to the evidence or documentation including the evidence-based standards, considered in reaching its decision.

3. Upon receipt of a notice of a decision pursuant to paragraph 1 of this subsection reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

J. The assignment by the Commissioner of an approved independent review organization to conduct an external review in accordance with this section shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other circumstances including conflict of interest concerns pursuant to subsection D of Section 6475.13 of this title.

Added by Laws 2011, c. 278, § 42. Amended by Laws 2011, c. 360, § 32; Laws 2022, c. 154, § 15, eff. Nov. 1, 2022.

§36-6475.9. Circumstances when external review request can be made.

A. Except as provided in subsection F of this section, a covered person or the covered person's authorized representative may make a request for an expedited external review with the Insurance Commissioner at the time the covered person receives:

1. An adverse determination if:
 - a. the adverse determination involves a medical condition of the covered person for which the time frame for completion of an expedited internal review of a grievance involving an adverse determination would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, and

- b. the covered person or the covered person's authorized representative has filed a request for an expedited review of a grievance involving an adverse determination; or
- 2. A final adverse determination:
 - a. if the covered person has a medical condition where the time frame for completion of a standard external review pursuant to Section 6475.8 of this title would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, or
 - b. if the final adverse determination concerns an admission, availability of care, continued stay or health care service for which the covered person received emergency services, but has not been discharged from a facility.

B. 1. Upon receipt of a request for an expedited external review, the Commissioner immediately shall send a copy of the request to the health carrier.

2. Immediately upon receipt of the request pursuant to paragraph 1 of this subsection, the health carrier shall determine whether the request meets the reviewability requirements set forth in subsection B of Section 6475.8 of this title. The health carrier shall immediately notify the Commissioner and the covered person and, if applicable, the covered person's authorized representative of its eligibility determination.

3. a. The Commissioner may specify the form for the health carrier's notice of initial determination under this subsection and any supporting information to be included in the notice.

b. The notice of initial determination shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that an external review request is ineligible for review may be appealed to the Commissioner.

4. a. The Commissioner may determine that a request is eligible for external review under subsection B of Section 6475.8 of this title notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review.

b. In making a determination under subparagraph a of this paragraph, the Commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all

applicable provisions of the Uniform Health Carrier External Review Act.

5. Upon receipt of the notice that the request meets the reviewability requirements, the Commissioner immediately shall assign an independent review organization to conduct the expedited external review from the list of approved independent review organizations compiled and maintained by the Commissioner pursuant to Section 6475.12 of this title. The Commissioner shall immediately notify the health carrier of the name of the assigned independent review organization.

6. In reaching a decision in accordance with subsection E of this section, the assigned independent review organization shall not be bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in Sections 6551 through 6565 of this title or the health carrier's internal grievance process.

C. Upon receipt of the notice from the Commissioner of the name of the independent review organization assigned to conduct the expedited external review pursuant to paragraph 5 of subsection B of this section, the health carrier or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

D. In addition to the documents and information provided or transmitted pursuant to subsection C of this section, the assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

1. The covered person's pertinent medical records;
2. The attending health care professional's recommendation;
3. Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative or the covered person's treating provider;
4. The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier;
5. The most appropriate practice guidelines, which shall include evidence-based standards, and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;

6. Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization in making adverse determinations; and

7. The opinion of the independent review organization's clinical reviewer or reviewers after considering paragraphs 1 through 6 of this subsection to the extent the information and documents are available and the clinical reviewer or reviewers consider appropriate.

E. 1. As expeditiously as the covered person's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the date of receipt of the request for an expedited external review that meets the reviewability requirements set forth in subsection B of Section 6475.8 of this title, the assigned independent review organization shall:

- a. make a decision to uphold or reverse the adverse determination or final adverse determination, and
- b. notify the covered person, if applicable, the covered person's authorized representative, the health carrier, and the Commissioner of the decision.

2. If the notice provided pursuant to paragraph 1 of this subsection was not in writing, within forty-eight (48) hours after the date of providing that notice, the assigned independent review organization shall:

- a. provide written confirmation of the decision to the covered person, if applicable, the covered person's authorized representative, the health carrier, and the Commissioner, and
- b. include the information set forth in paragraph 2 of subsection I of Section 6475.8 of this title.

3. Upon receipt of the notice of a decision pursuant to paragraph 1 of this subsection reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

F. An expedited external review may not be provided for retrospective adverse or final adverse determinations.

G. The assignment by the Commissioner of an approved independent review organization to conduct an external review in accordance with this section shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other circumstances including conflict of interest concerns pursuant to subsection D of Section 6475.13 of this title.

Added by Laws 2011, c. 278, § 43. Amended by Laws 2011, c. 360, § 33; Laws 2022, c. 154, § 16, eff. Nov. 1, 2022.

§36-6475.10. Timeframe for filing request for external review.

A. 1. Within four (4) months after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to Section 6475.5 of this title that involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, a covered person or the covered person's authorized representative may file a request for external review with the Insurance Commissioner.

2. a. A covered person or the covered person's authorized representative may make an oral request for an expedited external review of the adverse determination or final adverse determination pursuant to paragraph 1 of this subsection if the covered person's treating physician certifies, in writing, that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

b. Upon receipt of a request for an expedited external review, the Commissioner immediately shall notify the health carrier.

c. (1) Upon notice of the request for expedited external review, the health carrier immediately shall determine whether the request meets the reviewability requirements of subsection B of this section. The health carrier shall immediately notify the Commissioner and the covered person and, if applicable, the covered person's authorized representative of its eligibility determination.

(2) The Commissioner may specify the form for the health carrier's notice of initial determination under division (1) of this subparagraph and any supporting information to be included in the notice.

(3) The notice of initial determination under division (1) of this subparagraph shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that the external review request is ineligible for review may be appealed to the Commissioner.

d. (1) The Commissioner may determine that a request is eligible for external review under paragraph 2 of subsection B of this section notwithstanding a

health carrier's initial determination the request is ineligible and require that it be referred for external review.

- (2) In making a determination under division (1) of this subparagraph, the Commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of the Uniform Health Carrier External Review Act.
- e. Upon receipt of the notice that the expedited external review request meets the reviewability requirements of paragraph 2 of subsection B of this section, the Commissioner immediately shall assign an independent review organization to review the expedited request from the list of approved independent review organizations compiled and maintained by the Commissioner pursuant to Section 6475.12 of this title and notify the health carrier of the name of the assigned independent review organization.
- f. At the time the health carrier receives the notice of the assigned independent review organization pursuant to subparagraph e of this paragraph, the health carrier or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

B. 1. Except for a request for an expedited external review made pursuant to paragraph 2 of subsection A of this section, within one (1) business day after the date of receipt of the request, the Commissioner receives a request for an external review, the Commissioner shall notify the health carrier.

2. Within five (5) business days following the date of receipt of the notice sent pursuant to paragraph 1 of this subsection, the health carrier shall conduct and complete a preliminary review of the request to determine whether:

- a. the individual is or was a covered person in the health benefit plan at the time the health care service or treatment was recommended or requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the health care service or treatment was provided,
- b. the recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination:

- (1) is a covered benefit under the covered person's health benefit plan except for the health carrier's determination that the service or treatment is experimental or investigational for a particular medical condition, and
 - (2) is not explicitly listed as an excluded benefit under the covered person's health benefit plan with the health carrier,
- c. the covered person's treating physician has certified that one of the following situations is applicable:
- (1) standard health care services or treatments have not been effective in improving the condition of the covered person,
 - (2) standard health care services or treatments are not medically appropriate for the covered person, or
 - (3) there is no available standard health care service or treatment covered by the health carrier that is more beneficial than the recommended or requested health care service or treatment described in subparagraph d of this paragraph,
- d. the covered person's treating physician:
- (1) has recommended a health care service or treatment that the physician certifies, in writing, is likely to be more beneficial to the covered person, in the physician's opinion, than any available standard health care services or treatments, or
 - (2) who is a licensed, board-certified or board-eligible physician qualified to practice in the area of medicine appropriate to treat the covered person's condition, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by the covered person that is the subject of the adverse determination or final adverse determination is likely to be more beneficial to the covered person than any available standard health care services or treatments,
- e. the covered person has exhausted the health carrier's internal grievance process unless the covered person is not required to exhaust the health carrier's internal grievance process pursuant to Section 6475.7 of this title, and

- f. the covered person has provided all the information and forms required by the Commissioner that are necessary to process an external review including the release form provided under subsection B of Section 6475.5 of this title.

C. 1. Within one (1) business day after completion of the preliminary review, the health carrier shall notify the Commissioner and the covered person and, if applicable, the covered person's authorized representative in writing whether:

- a. the request is complete, and
- b. the request is eligible for external review.

2. If the request:

- a. is not complete, the health carrier shall inform in writing the Commissioner and the covered person and, if applicable, the covered person's authorized representative and include in the notice what information or materials are needed to make the request complete, or
- b. is not eligible for external review, the health carrier shall inform the covered person, the covered person's authorized representative, if applicable, and the Commissioner in writing and include in the notice the reasons for its ineligibility.

3. a. The Commissioner may specify the form for the health carrier's notice of initial determination under paragraph 2 of this subsection and any supporting information to be included in the notice.

- b. The notice of initial determination provided under paragraph 2 of this subsection shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that the external review request is ineligible for review may be appealed to the Commissioner.

4. a. The Commissioner may determine that a request is eligible for external review under paragraph 2 of subsection B of this section notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review.

- b. In making a determination under subparagraph a of this paragraph, the Commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of the Uniform Health Carrier External Review Act.

5. Whenever a request for external review is determined eligible for external review, the health carrier shall notify the Commissioner and the covered person and, if applicable, the covered person's authorized representative.

D. 1. Within one (1) business day after the receipt of the notice from the health carrier that the external review request is eligible for external review pursuant to subparagraph d of paragraph 2 of subsection A of this section or paragraph 5 of subsection C of this section, the Commissioner shall:

- a. assign an independent review organization to conduct the external review from the list of approved independent review organizations compiled and maintained by the Commissioner pursuant to Section 6475.12 of this title and notify the health carrier of the name of the assigned independent review organization, and
- b. notify in writing the covered person and, if applicable, the covered person's authorized representative of the request's eligibility and acceptance for external review.

2. The Commissioner shall include in the notice provided to the covered person and, if applicable, the covered person's authorized representative a statement that the covered person or the covered person's authorized representative may submit in writing to the assigned independent review organization within five (5) business days following the date of receipt of the notice provided pursuant to paragraph 1 of this subsection, additional information that the independent review organization shall consider when conducting the external review. The independent review organization is not required to, but may, accept and consider additional information submitted after five (5) business days.

3. Within one (1) business day after the receipt of the notice of assignment to conduct the external review pursuant to paragraph 1 of this subsection, the assigned independent review organization shall:

- a. select one or more clinical reviewers, as it determines is appropriate, pursuant to paragraph 4 of this subsection to conduct the external review, and
- b. based on the opinion of the clinical reviewer, or opinions if more than one clinical reviewer has been selected to conduct the external review, make a decision to uphold or reverse the adverse determination or final adverse determination.

4. a. In selecting clinical reviewers pursuant to subparagraph a of paragraph 3 of this subsection, the assigned independent review organization shall select physicians or other health care professionals who meet

the minimum qualifications described in Section 6475.13 of this title and, through clinical experience in the past three (3) years, are experts in the treatment of the covered person's condition and knowledgeable about the recommended or requested health care service or treatment.

- b. Neither the covered person, the covered person's authorized representative, if applicable, nor the health carrier, shall choose or control the choice of the physicians or other health care professionals to be selected to conduct the external review.

5. In accordance with subsection H of this section, each clinical reviewer shall provide a written opinion to the assigned independent review organization on whether the recommended or requested health care service or treatment should be covered.

6. In reaching an opinion, clinical reviewers are not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in Sections 6551 through 6565 of this title or the health carrier's internal grievance process.

E. 1. Within five (5) business days after the date of receipt of the notice provided pursuant to paragraph 1 of subsection D of this section, the health carrier or its designee utilization review organization shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or the final adverse determination.

2. Except as provided in paragraph 3 of this subsection, failure by the health carrier or its designee utilization review organization to provide the documents and information within the time specified in paragraph 1 of this subsection shall not delay the conduct of the external review.

- 3. a. If the health carrier or its designee utilization review organization has failed to provide the documents and information within the time specified in paragraph 1 of this subsection, the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

- b. Immediately upon making the decision under subparagraph a of this paragraph, the independent review organization shall notify the covered person, the covered person's authorized representative, if applicable, the health carrier, and the Commissioner.

F. 1. Each clinical reviewer selected pursuant to subsection D of this section shall review all of the information and documents received pursuant to subsection E of this section and any other information submitted in writing by the covered person or the

covered person's authorized representative pursuant to paragraph 2 of subsection D of this section.

2. Upon receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to paragraph 2 of subsection D of this section, within one (1) business day after the receipt of the information, the assigned independent review organization shall forward the information to the health carrier.

G. 1. Upon receipt of the information required to be forwarded pursuant to paragraph 2 of subsection F of this section, the health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.

2. Reconsideration by the health carrier of its adverse determination or final adverse determination pursuant to paragraph 1 of this subsection shall not delay or terminate the external review.

3. The external review may be terminated only if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination.

4. a. Immediately upon making the decision to reverse its adverse determination or final adverse determination, as provided in paragraph 3 of this subsection, the health carrier shall notify the covered person, the covered person's authorized representative if applicable, the assigned independent review organization, and the Commissioner in writing of its decision.

b. The assigned independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to subparagraph a of this paragraph.

H. 1. Except as provided in paragraph 3 of this subsection, within twenty (20) days after being selected in accordance with subsection D of this section to conduct the external review, each clinical reviewer shall provide an opinion to the assigned independent review organization pursuant to subsection I of this section on whether the recommended or requested health care service or treatment should be covered.

2. Except for an opinion provided pursuant to paragraph 3 of this subsection, each clinical reviewer's opinion shall be in writing and include the following information:

- a. a description of the covered person's medical condition,
- b. a description of the indicators relevant to determining whether there is sufficient evidence to

demonstrate that the recommended or requested health care service or treatment is more likely than not to be beneficial to the covered person than any available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments,

- c. a description and analysis of any medical or scientific evidence, as that term is defined in Section 6475.3 of this title, considered in reaching the opinion,
 - d. a description and analysis of any evidence-based standard, as that term is defined in Section 6475.3 of this title, and
 - e. information on whether the reviewer's rationale for the opinion is based on subparagraph a or b of paragraph 5 of subsection I of this section.
3. a. For an expedited external review, each clinical reviewer shall provide an opinion orally or in writing to the assigned independent review organization as expeditiously as the covered person's medical condition or circumstances require, but in no event more than five (5) calendar days after being selected in accordance with subsection D of this section.
- b. If the opinion provided pursuant to subparagraph a of this paragraph was not in writing, within forty-eight (48) hours following the date the opinion was provided the clinical reviewer shall provide written confirmation of the opinion to the assigned independent review organization and include the information required under paragraph 2 of this subsection.

I. In addition to the documents and information provided pursuant to paragraph 2 of subsection A of this section or subsection E of this section, each clinical reviewer selected pursuant to subsection D of this section, to the extent the information or documents are available and the reviewer considers appropriate, shall consider the following in reaching an opinion pursuant to subsection H of this section:

- 1. The covered person's pertinent medical records;
- 2. The attending physician or health care professional's recommendation;
- 3. Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative, or the covered person's treating physician or health care professional;

4. The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that, but for the health carrier's determination that the recommended or requested health care service or treatment that is the subject of the opinion is experimental or investigational, the reviewer's opinion is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier; and

5. Whether:

- a. the recommended or requested health care service or treatment has been approved by the federal Food and Drug Administration, if applicable, for the condition, or
- b. medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested health care service or treatment is more likely than not to be beneficial to the covered person than any available standard health care service or treatment and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments.

J. 1. a. Except as provided in subparagraph b of this paragraph, within twenty (20) days after the date it receives the opinion of each clinical reviewer pursuant to subsection I of this section, the assigned independent review organization, in accordance with paragraph 2 of this subsection, shall make a decision and provide written notice of the decision to:

- (1) the covered person,
 - (2) if applicable, the covered person's authorized representative,
 - (3) the health carrier, and
 - (4) the Commissioner.
- b. (1) For an expedited external review, within forty-eight (48) hours after the date it receives the opinion of each clinical reviewer pursuant to subsection I of this section, the assigned independent review organization, in accordance with paragraph 2 of this subsection, shall make a decision and provide notice of the decision orally or in writing to the persons listed in subparagraph a of this paragraph.
- (2) If the notice provided under division (1) of this subparagraph was not in writing, within forty-eight (48) hours after the date of providing that notice, the assigned independent review

organization shall provide written confirmation of the decision to the persons listed in subparagraph a of this paragraph and include the information set forth in paragraph 3 of this subsection.

2. a. If a majority of the clinical reviewers recommend that the recommended or requested health care service or treatment should be covered, the independent review organization shall make a decision to reverse the health carrier's adverse determination or final adverse determination.
- b. If a majority of the clinical reviewers recommend that the recommended or requested health care service or treatment should not be covered, the independent review organization shall make a decision to uphold the health carrier's adverse determination or final adverse determination.
- c. (1) If the clinical reviewers are evenly split as to whether the recommended or requested health care service or treatment should be covered, the independent review organization shall obtain the opinion of an additional clinical reviewer in order for the independent review organization to make a decision based on the opinions of a majority of the clinical reviewers pursuant to subparagraph a or b of this paragraph.
- (2) The additional clinical reviewer selected under division (1) of this subparagraph shall use the same information to reach an opinion as the clinical reviewers who have already submitted their opinions pursuant to subsection I of this section.
- (3) The selection of the additional clinical reviewer under this subparagraph shall not extend the time within which the assigned independent review organization is required to make a decision based on the opinions of the clinical reviewers selected pursuant to paragraph 1 of subsection D of this section.

3. The independent review organization shall include in the notice provided pursuant to paragraph 1 of this subsection:

- a. a general description of the reason for the request for external review,
- b. the written opinion of each clinical reviewer including the recommendation of each clinical reviewer as to whether the recommended or requested health care

- service or treatment should be covered and the rationale for the reviewer's recommendation,
- c. the date the independent review organization was assigned by the Commissioner to conduct the external review,
 - d. the date the external review was conducted,
 - e. the date of its decision,
 - f. the principal reason or reasons for its decision, and
 - g. the rationale for its decision.

4. Upon receipt of a notice of a decision pursuant to paragraph 1 of this subsection reversing the adverse determination or final adverse determination, the health carrier immediately shall approve coverage of the recommended or requested health care service or treatment that was the subject of the adverse determination or final adverse determination.

K. The assignment by the Commissioner of an approved independent review organization to conduct an external review in accordance with this section shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other circumstances including conflict of interest concerns pursuant to subsection D of Section 6475.13 of this title.

Added by Laws 2011, c. 278, § 44. Amended by Laws 2011, c. 360, § 34; Laws 2022, c. 154, § 17, eff. Nov. 1, 2022.

§36-6475.11. Binding power of external review decision.

A. An external review decision is binding on the health carrier except to the extent the health carrier has other remedies available under applicable state law.

B. An external review decision is binding on the covered person except to the extent the covered person has other remedies available under applicable federal or state law.

C. A covered person or the covered person's authorized representative shall not file a subsequent request for external review involving the same adverse determination or final adverse determination for which the covered person has already received an external review decision pursuant to the Uniform Health Carrier External Review Act.

Added by Laws 2011, c. 278, § 45 and Laws 2011, c. 360, § 35.

NOTE: Laws 2011, c. 278, § 45 and Laws 2011, c. 360, § 35 added identical sections under the same number.

§36-6475.12. Approval of independent review organizations.

A. The Insurance Commissioner shall approve independent review organizations eligible to be assigned to conduct external reviews under the Uniform Health Carrier External Review Act.

B. In order to be eligible for approval by the Commissioner under this section to conduct external reviews under the Uniform Health Carrier External Review Act an independent review organization:

1. Except as otherwise provided in this section, shall be accredited by a nationally recognized private accrediting entity that the Commissioner has determined has independent review organization accreditation standards that are equivalent to or exceed the minimum qualifications for independent review organizations established under Section 6475.13 of this title; and

2. Shall submit an application for approval in accordance with subsection D of this section.

C. The Commissioner shall develop an application form by rule for initially approving and for reapproving independent review organizations to conduct external reviews.

D. 1. Any independent review organization wishing to be approved to conduct external reviews under this act shall submit the application form and include with the form all documentation and information necessary for the Commissioner to determine if the independent review organization satisfies the minimum qualifications established under Section 6475.13 of this title.

2. a. Subject to subparagraph b of this paragraph, an independent review organization is eligible for approval under this section only if it is accredited by a nationally recognized private accrediting entity that the Commissioner has determined has independent review organization accreditation standards that are equivalent to or exceed the minimum qualifications for independent review organizations under Section 6475.13 of this title.

b. The Commissioner may approve independent review organizations that are not accredited by a nationally recognized private accrediting entity if there are no acceptable nationally recognized private accrediting entities providing independent review organization accreditation.

3. The Commissioner may charge an application fee that independent review organizations shall submit to the Commissioner with an application for approval and reapproval.

E. 1. An approval is effective for two (2) years, unless the Commissioner determines before its expiration that the independent review organization is not satisfying the minimum qualifications established under Section 6475.14 of this title.

2. Whenever the Commissioner determines that an independent review organization has lost its accreditation or no longer satisfies the minimum requirements established under Section 6475.14 of this title, the Commissioner shall terminate the approval of the independent review organization and remove the independent review organization from the list of independent review organizations approved to conduct external reviews under the Uniform Health Carrier External Review Act that is maintained by the Commissioner pursuant to subsection F of this section.

F. The Commissioner shall maintain and periodically update a list of approved independent review organizations.

G. The Commissioner may promulgate rules to carry out the provisions of this section.

Added by Laws 2011, c. 278, § 46. Amended by Laws 2011, c. 360, § 36; Laws 2022, c. 154, § 18, eff. Nov. 1, 2022.

§36-6475.13. Eligibility requirements.

A. To be approved under Section 6475.12 of this title to conduct external reviews, an independent review organization shall have and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process set forth in this act that include, at a minimum:

1. A quality assurance mechanism in place that:

- a. ensures that external reviews are conducted within the specified time frames and required notices are provided in a timely manner,
- b. ensures the selection of qualified and impartial clinical reviewers to conduct external reviews on behalf of the independent review organization and suitable matching of reviewers to specific cases and that the independent review organization employs or contracts with an adequate number of clinical reviewers to meet this objective,
- c. ensures the confidentiality of medical and treatment records and clinical review criteria, and
- d. ensures that any person employed by or under contract with the independent review organization adheres to the requirements of the Uniform Health Carrier External Review Act;

2. A toll-free telephone service to receive information on a twenty-four-hour-a-day, seven-day-a-week basis related to external reviews that is capable of accepting, recording or providing appropriate instruction to incoming telephone callers during other than normal business hours; and

3. Agree to maintain and provide to the Insurance Commissioner the information set out in Section 6475.15 of this title.

B. All clinical reviewers assigned by an independent review organization to conduct external reviews shall be physicians or other appropriate health care providers who meet the following minimum qualifications:

1. Be an expert in the treatment of the covered person's medical condition that is the subject of the external review;

2. Be knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical condition of the covered person;

3. Hold a nonrestricted license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review; and

4. Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical reviewer's physical, mental or professional competence or moral character.

C. In addition to the requirements set forth in subsection A of this section, an independent review organization may not own or control, be a subsidiary of or in any way be owned or controlled by, or exercise control with a health benefit plan, a national, state or local trade association of health benefit plans, or a national, state or local trade association of health care providers.

D. 1. In addition to the requirements set forth in subsections A, B and C of this section, to be approved pursuant to Section 6475.12 of this title to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review nor any clinical reviewer assigned by the independent organization to conduct the external review may have a material professional, familial or financial conflict of interest with any of the following:

a. the health carrier that is the subject of the external review,

b. the covered person whose treatment is the subject of the external review or the covered person's authorized representative,

c. any officer, director or management employee of the health carrier that is the subject of the external review,

d. the health care provider, the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the external review,

- e. the facility at which the recommended health care service or treatment would be provided, or
- f. the developer or manufacturer of the principal drug, device, procedure or other therapy being recommended for the covered person whose treatment is the subject of the external review.

2. In determining whether an independent review organization or a clinical reviewer of the independent review organization has a material professional, familial or financial conflict of interest for purposes of paragraph 1 of this subsection, the Commissioner shall take into consideration situations where the independent review organization to be assigned to conduct an external review of a specified case or a clinical reviewer to be assigned by the independent review organization to conduct an external review of a specified case may have an apparent professional, familial or financial relationship or connection with a person described in paragraph 1 of this subsection, but that the characteristics of that relationship or connection are such that they are not a material professional, familial or financial conflict of interest that results in the disapproval of the independent review organization or the clinical reviewer from conducting the external review.

E. In addition to the requirements set forth in subsections A, B, C and D of this section, an independent review organization shall possess any additional minimum qualifications that the Insurance Commissioner may promulgate by rule.

F. 1. An independent review organization that is accredited by a nationally recognized private accrediting entity that has independent review accreditation standards that the Commissioner has determined are equivalent to or exceed the minimum qualifications of this section shall be presumed in compliance with this section to be eligible for approval under Section 6475.12 of this title. If a nationally recognized private accrediting entity has independent review accreditation standards that are substantially similar to but do not equal or exceed the minimum qualifications of this section, the Commissioner may accept the accreditation as an equivalent accreditation standard after reviewing for compliance any minimum qualifications required by this section that are not required by the national accreditation.

2. The Commissioner shall initially review and periodically review the independent review organization accreditation standards of a nationally recognized private accrediting entity to determine whether the entity's standards are, and continue to be, equivalent to or exceed the minimum qualifications established under this section. The Commissioner may accept a review conducted by the NAIC for the purpose of the determination under this paragraph.

3. Upon request, a nationally recognized private accrediting entity shall make its current independent review organization

accreditation standards available to the Commissioner or the NAIC in order for the Commissioner to determine if the entity's standards are equivalent to or exceed the minimum qualifications established under this section. The Commissioner may exclude any private accrediting entity that is not reviewed by the NAIC.

G. An independent review organization shall be unbiased. An independent review organization shall establish and maintain written procedures to ensure that it is unbiased in addition to any other procedures required under this section.

Added by Laws 2011, c. 278, § 47. Amended by Laws 2011, c. 360, § 37; Laws 2012, c. 44, § 16, eff. Nov. 1, 2012.

§36-6475.14. Employee liability.

No independent review organization or clinical reviewer working on behalf of an independent review organization or an employee, agent or contractor of an independent review organization shall be liable in damages to any person for any opinions rendered or acts or omissions performed within the scope of the organization's or person's duties under the law during or upon completion of an external review conducted pursuant to the Uniform Health Carrier External Review Act, unless the opinion was rendered or act or omission performed in bad faith or involved gross negligence.

Added by Laws 2011, c. 278, § 48. Amended by Laws 2011, c. 360, § 38.

§36-6475.15. Written records.

A. 1. An independent review organization assigned pursuant to Section 6475.8, 6475.9, or 6475.10 of this title to conduct an external review shall maintain written records in the aggregate by state and by health carrier on all requests for external review for which it conducted an external review during a calendar year and, upon request, submit a report to the Insurance Commissioner, as required under paragraph 2 of this subsection.

2. Each independent review organization required to maintain written records on all requests for external review pursuant to paragraph 1 of this subsection for which it was assigned to conduct an external review shall submit to the Commissioner, upon request, a report in the format specified by the Commissioner.

3. The report shall include in the aggregate by state, and for each health carrier:

- a. the total number of requests for external review,
- b. the number of requests for external review resolved and, of those resolved, the number resolved upholding the adverse determination or final adverse determination and the number resolved reversing the adverse determination or final adverse determination,
- c. the average length of time for resolution,

- d. a summary of the types of coverages or cases for which an external review was sought, as provided in the format required by the Commissioner,
- e. the number of external reviews pursuant to subsection G of Section 6475.8 of this title that were terminated as the result of a reconsideration by the health carrier of its adverse determination or final adverse determination after the receipt of additional information from the covered person or the covered person's authorized representative, and
- f. any other information the Commissioner may request or require.

4. The independent review organization shall retain the written records required pursuant to this subsection for at least three (3) years.

B. 1. Each health carrier shall maintain written records in the aggregate, by state and for each type of health benefit plan offered by the health carrier on all requests for external review that the health carrier receives notice of from the Commissioner pursuant to this act.

2. Each health carrier required to maintain written records on all requests for external review pursuant to paragraph 1 of this subsection shall submit to the Commissioner, upon request, a report in the format specified by the Commissioner.

3. The report shall include in the aggregate, by state, and by type of health benefit plan:

- a. the total number of requests for external review,
- b. from the total number of requests for external review reported under subparagraph a of this paragraph, the number of requests determined eligible for a full external review, and
- c. any other information the Commissioner may request or require.

4. The health carrier shall retain the written records required pursuant to this subsection for at least three (3) years.

Added by Laws 2011, c. 278, § 49. Amended by Laws 2011, c. 360, § 39; Laws 2022, c. 154, § 19, eff. Nov. 1, 2022.

§36-6475.16. Cost of independent review organization.

The health carrier against which a request for a standard external review or an expedited external review is filed shall pay the cost of the independent review organization for conducting the external review.

Added by Laws 2011, c. 278, § 50 and Laws 2011, c. 360, § 40.

NOTE: Laws 2011, c. 278, § 50 and Laws 2011, c. 360, § 40 added identical sections under the same number.

§36-6475.17. Description of external review procedures.

A. 1. Each health carrier shall include a description of the external review procedures in or attached to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage it provides to covered persons.

2. The disclosure required by paragraph 1 of this subsection shall be in a format prescribed by the Insurance Commissioner.

B. The description required under subsection A of this section shall include a statement that informs the covered person of the right of the covered person to file a request for an external review of an adverse determination or final adverse determination with the Commissioner. The statement shall explain that external review is available when the adverse determination or final adverse determination involves an issue of medical necessity, appropriateness, health care setting, level of care or effectiveness. The statement shall include the telephone number and address of the Commissioner.

C. In addition to subsection B of this section, the statement shall inform the covered person that, when filing a request for an external review, the covered person will be required to authorize the release of any medical records of the covered person that may be required to be reviewed for the purpose of reaching a decision on the external review.

Added by Laws 2011, c. 278, § 51 and Laws 2011, c. 360, § 41.

NOTE: Laws 2011, c. 278, § 51 and Laws 2011, c. 360, § 41 added identical sections under the same number.

§36-6501. Repealed by Laws 1997, c. 109, § 5, eff. Nov. 1, 1997.

§36-6502. Repealed by Laws 1997, c. 109, § 5, eff. Nov. 1, 1997.

§36-6503. Repealed by Laws 1997, c. 109, § 5, eff. Nov. 1, 1997.

§36-6504. Repealed by Laws 1997, c. 109, § 5, eff. Nov. 1, 1997.

§36-6505. Repealed by Laws 1997, c. 109, § 5, eff. Nov. 1, 1997.

§36-6506. Repealed by Laws 1997, c. 109, § 5, eff. Nov. 1, 1997.

§36-6507. Repealed by Laws 1997, c. 109, § 5, eff. Nov. 1, 1997.

§36-6511. Short title.

Sections 6511 through 6518 and Sections 5 through 15 of this act shall be known and may be cited as the "Small Employer Health Insurance Reform Act".

Added by Laws 1992, c. 329, § 1, eff. Sept. 1, 1992. Amended by Laws 1994, c. 211, § 1, eff. July 1, 1994.

§36-6512. Definitions.

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 examination of the person, 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", "controlling", "controlled by" or "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 the 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 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 temporary or substitute basis;

14. "Established geographic service area" means a geographic area, as approved by the Commissioner and based on the certificate of authority of the carrier 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, workers'

compensation or similar insurance, 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 those 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 May 20, 1994, 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 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 health benefit plan of a covered employee 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. "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;

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

21. "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 Sections 6901 through 6936 of this title, that provides benefits similar to or exceeding the benefits provided under the basic health benefit plan, provided

that the policy has been in effect for a period of at least one (1) year;

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

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

24. "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 Sections 6901 through 6963 of this title to provide health care services to covered individuals;

25. "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; and

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

Added by Laws 1992, c. 329, § 2, eff. Sept. 1, 1992. Amended by Laws 1994, c. 211, § 2, eff. July 1, 1994; Laws 1998, c. 304, § 2, eff. July 1, 1998; Laws 2000, c. 353, § 47, eff. Nov. 1, 2000; Laws 2001, c. 363, § 25, eff. July 1, 2001; Laws 2009, c. 176, § 50, eff. Nov. 1, 2009; Laws 2010, c. 222, § 43, eff. Nov. 1, 2010; Laws 2012, c. 151, § 1, eff. Nov. 1, 2012; Laws 2019, c. 265, § 1, eff. Nov. 1, 2019.

§36-6513. Application of act to certain group health benefit plans.

A. Except as otherwise provided in this section and in Section 3 of this act, the Small Employer Health Insurance Reform Act shall apply to any group health benefit plan that provides coverage to two (2) or more eligible employees of a small employer in this state and to individual health benefits plans providing coverage for the eligible employees of a small employer which may include the employer when three (3) or more of such individual plans are sold to a small employer if any of the following conditions are met:

1. Any portion of the premium or benefits is paid by or on behalf of the small employer;

2. An eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium; or

3. The health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of Section 162 or Section 106 of the United States Internal Revenue Code.

B. 1. Except as provided in paragraph 2 of this subsection, for the purposes of the Small Employer Health Insurance Reform Act, carriers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one carrier and any restrictions or limitations imposed by the Small Employer Health Insurance Reform Act shall apply as if all health benefit plans issued to small employers in this state by such affiliated carriers were issued by one carrier, unless on or before July 1, 1992, the respective affiliate carriers operated with separate books of business as insurers of health benefit plans in which event each such affiliate carrier shall be treated as a separate carrier.

2. An affiliated carrier that is a health maintenance organization granted a certificate of authority by the Insurance Commissioner pursuant to the provisions of Sections 6901 through 6951 of Title 36 of the Oklahoma Statutes may be considered to be a separate carrier for the purposes of the Small Employer Health Insurance Reform Act.

Added by Laws 1992, c. 329, § 3, eff. Sept. 1, 1992. Amended by Laws 1994, c. 211, § 3, eff. July 1, 1994; Laws 1999, c. 360, § 1, eff. July 1, 1999; Laws 2000, c. 171, § 3, eff. July 1, 2000; Laws 2012, c. 151, § 2, eff. Nov. 1, 2012; Laws 2019, c. 265, § 2, eff. Nov. 1, 2019.

§36-6514. Classes of business - Criteria to establish - Number - Rules - Additional classes.

A. A small employer carrier may establish a class of business only to reflect substantial differences in expected claims experience or administrative costs related to the following reasons:

1. The small employer carrier uses more than one type of system for the marketing and sale of health benefit plans to small employers;

2. The small employer carrier has acquired a class of business from another small employer carrier; or

3. The small employer carrier provides coverage to one or more association groups that meet the requirements of an association as set forth in Section 4501 of this title.

B. A small employer carrier may establish up to nine separate classes of business under subsection A of this section.

C. The Insurance Commissioner may establish rules to provide for a period of transition in order for a small employer carrier to

come into compliance with subsection B of this section in the instance of acquisition of an additional class of business from another small employer carrier.

D. The Commissioner may approve the establishment of additional classes of business upon application to the Commissioner and a finding by the Commissioner that such action would enhance the efficiency and fairness of the small employer marketplace.

E. A small employer carrier shall offer each product currently marketed to all classes of business established pursuant to this section.

Added by Laws 1992, c. 329, § 4, eff. Sept. 1, 1992. Amended by Laws 2001, c. 363, § 26, eff. July 1, 2001.

§36-6515. Premium rates.

A. Premium rates for health benefit plans subject to the Small Employer Health Insurance Reform Act shall be subject to the following provisions:

1. The rate manual developed for use by a small employer carrier shall be filed and approved by the Insurance Commissioner prior to use. Any changes to the rate manual shall be filed and approved by the Insurance Commissioner prior to use. Every filing shall be made not less than thirty (30) days prior to the date the small employer carrier intends to implement the rates. The rate manual so filed shall be deemed approved upon expiration of the thirty-day waiting period unless, prior to the end of the period, it has been affirmatively approved or disapproved by order of the Commissioner. Approval of a rate manual by the Commissioner shall constitute a waiver of any unexpired portion of the thirty-day waiting period. The Commissioner may extend the period to approve or disapprove a rate manual by not more than an additional thirty (30) days by giving notice of such extension before expiration of the initial thirty-day period. At the expiration of an extended period, the rate filing shall be deemed approved unless otherwise approved or disapproved by the Commissioner. The Commissioner may at any time, after notice and for cause shown, withdraw approval of a filed rate;

2. A small employer health benefit plan shall not be delivered or issued for delivery unless the policy form or certificate form can be expected to return to policyholders and certificate holders in the form of aggregate benefits provided under the policy form or certificate form at least sixty percent (60%) of the aggregate amount of premiums earned. The rate of return shall be estimated for the entire period for which rates are computed to provide coverage. The rate of return shall be calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the

period in accordance with accepted actuarial principles and practices;

3. The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twenty percent (20%);

4. For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to such employers under the rating system for that class of business, shall not vary from the index rate by more than twenty-five percent (25%) of the index rate;

5. The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

- a. the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers,
- b. any adjustment, not to exceed fifteen percent (15%) annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer as determined from the rate manual for the class of business of the small employer carrier, and
- c. any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined from the rate manual for the class of business of the small employer carrier;

6. Adjustments in rates for claim experience, health status and duration of coverage shall not be charged to individual employees or dependents. Any adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer;

7. A small employer carrier may utilize industry as a case characteristic in establishing premium rates; provided, the highest rate factor associated with any industry classification shall not exceed the lowest rate factor associated with any industry classification by more than fifteen percent (15%);

8. In the case of health benefit plans issued prior to the effective date of the Small Employer Health Insurance Reform Act, a premium rate for a rating period may exceed the ranges set forth in paragraphs 3 and 4 of this subsection for a period of three (3) years following the effective date of the Small Employer Health Insurance Reform Act. In such case, the percentage increase in the premium rate charged to a small employer for a new rating period shall not exceed the sum of the following:

- a. the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers, and
- b. any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined from the rate manual of the carrier for the class of business;

9. Small employer carriers shall:

- a. apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors shall produce premiums for identical groups within the same class of business which differ only by amounts attributable to plan design and do not reflect differences due to claims experience, health status and duration of coverage, and
- b. treat all health benefit plans issued or renewed in the same calendar month as having the same rating period;

10. For the purposes of this subsection, a health benefit plan that utilizes a restricted provider network shall not be considered similar coverage to a health benefit plan that does not utilize such a network, provided that utilization of the restricted provider network results in substantial differences in claims costs;

11. The Insurance Commissioner may establish rules to implement the provisions of this section and to assure that rating practices used by small employer carriers are consistent with the purposes of the Small Employer Health Insurance Reform Act, including:

- a. assuring that differences in rates charged for health benefit plans by small employer carriers are

reasonable and reflect objective differences in plan design, not including differences due to claims experience, health status or duration of coverage, and

b. prescribing the manner in which case characteristics may be used by small employer carriers.

B. A small employer carrier shall not transfer a small employer involuntarily into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless the offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration of coverage.

C. The Commissioner may suspend for a specified period the application of paragraph 3 of subsection A of this section as to the premium rates applicable to one or more small employers included within a class of business of a small employer carrier for one or more rating periods upon a filing by the small employer carrier and a finding by the Commissioner either that the suspension is reasonably necessary in light of the financial condition of the small employer carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

D. Nothing in the Small Employer Health Insurance Reform Act shall prohibit a small employer carrier from including in premium rate development an employer's bona fide wellness program for its employees including, but not limited to, a tobacco cessation program.

Added by Laws 1992, c. 329, § 5, eff. Sept. 1, 1992. Amended by Laws 1994, c. 211, § 4, eff. July 1, 1994; Laws 1998, c. 304, § 3, eff. July 1, 1998; Laws 2010, c. 222, § 44, eff. Nov. 1, 2010; Laws 2013, c. 103, § 1, eff. Nov. 1, 2013, **and** c. 269, § 15, eff. Nov. 1, 2013.

NOTE: Laws 2013, c. 103, § 1 and Laws 2013, c. 269, § 15 made identical changes to this section.

§36-6516. Renewability of health benefit plans - Election not to renew - Geographic service area.

A. A health benefit plan subject to this act shall be renewable with respect to all eligible employees and dependents, at the option of the small employer, except in any of the following cases:

1. Nonpayment of the required premiums;
2. Fraud or misrepresentation of the small employer or, with respect to coverage of individual insureds, the insureds or their representatives;
3. Noncompliance with the carrier's minimum group participation requirements;

4. Noncompliance with the carrier's employer contribution requirements;

5. Repeated misuse of provider network provisions;

6. The small employer carrier elects to nonrenew all of its health benefit plans issued to small employers in this state. In such a case the carrier shall:

a. provide advance notice of its decision under this paragraph to the Insurance Commissioner in each state in which it is licensed, and

b. provide notice of the decision not to renew coverage to all affected small employers and to the Commissioner in each state in which an affected covered individual is known to reside at least one hundred eighty (180) days prior to the nonrenewal of any health benefit plan by the carrier. Notice to the Commissioner under this subparagraph shall be provided at least three (3) working days prior to the notice to the affected small employers; or

7. The Commissioner finds that the continuation of the coverage would:

a. not be in the best interests of the policyholders or certificate holders, or

b. impair the carrier's ability to meet its contractual obligations. In such instance the Commissioner may assist affected small employers in finding replacement coverage.

B. A small employer carrier that elects not to renew a health benefit plan under paragraph 6 of subsection A of this section shall be prohibited from writing new business in the small employer market in this state for a period of five (5) years from the date of notice to the Commissioner.

C. In the case of a small employer carrier doing business in one established geographic service area of the state, the provisions of this section shall apply only to the carrier's operations in such service area.

Added by Laws 1992, c. 329, § 6, eff. Sept. 1, 1992.

§36-6517. Disclosures required of small employer carriers.

In connection with the offering for sale of any health benefit plan to a small employer, a small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:

1. The extent to which premium rates for a specified small employer are established or adjusted based upon the actual or expected variation in claims costs or actual or expected variation in health status of the employees of the small employer and their dependents;

2. The provisions of the health benefit plan concerning the small employer carrier's right to change premium rates and factors, other than claim experience, that affect changes in premium rates;

3. The provisions relating to renewability of policies and contracts; and

4. The provisions relating to any preexisting condition provision.

Added by Laws 1992, c. 329, § 7, eff. Sept. 1, 1992.

§36-6518. Maintenance and disclosure of certain information and documents - Filing of actuarial certification.

A. Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

B. Each small employer carrier shall file with the Insurance Commissioner annually on or before March 15 an actuarial certification certifying that the carrier is in compliance with this act and that the rating methods of the small employer carrier are actuarially sound. Such certification shall be in a form and manner, and shall contain such information, as specified by the Commissioner. A copy of the certification shall be retained by the small employer carrier at its principal place of business.

C. A small employer carrier shall make the information and documentation described in subsection A of this section available to the Commissioner upon request. Except in cases of violations of this act, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the Commissioner to persons outside of the Department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

Added by Laws 1992, c. 329, § 8, eff. Sept. 1, 1992.

§36-6519. Basic and standard health benefit plans - Condition of transacting business - Filing with Commissioner - Required compliance with certain provisions - Exceptions.

A. 1. As a condition of transacting business in this state with small employers, every small employer carrier shall actively offer to small employers the health benefit plans currently being marketed by the small employer carrier.

2. a. A small employer carrier shall issue a health benefit plan to any eligible small employer that applies for a plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the

health benefit plan not inconsistent with Section 6511 et seq. of this title.

- b. In the case of a small employer carrier that establishes more than one class of business pursuant to Section 6514 of this title, the small employer carrier shall maintain and issue to eligible small employers all health benefit plans currently being marketed in each class of business so established. A small employer carrier may apply reasonable criteria to determine the class of business applicable to any small employer, provided that:
- (1) the criteria are not intended to discourage or prevent acceptance of small employers applying for a health benefit plan,
 - (2) the criteria are not related to the health status or claim experience of the small employer,
 - (3) the criteria are applied consistently to all small employers applying for coverage in the class of business, and
 - (4) the small employer carrier provides for the acceptance of all eligible small employers into one or more classes of business.

The provisions of this subparagraph shall not apply to a class of business into which the small employer carrier is no longer enrolling new small businesses.

3. A small employer is eligible under paragraph 2 of this subsection if it employed at least two or more eligible employees within this state on at least fifty percent (50%) of its working days during the preceding calendar quarter. This also includes family businesses where employees of the business may be related. The fact that the employees are related shall have no effect on the eligibility for coverage of the small employer.

4. A small employer carrier that offers a health benefit plan in the small employer market only through one or more bona fide association health plans is not required to offer that health benefit plan to any small employer that is not a member of the bona fide association sponsoring the bona fide association health plan.

B. 1. A small employer carrier shall file with the Commissioner, in a format and manner prescribed by the Commissioner, all health benefit plans to be used by the carrier. A health benefit plan filed pursuant to this paragraph may be used by a small employer carrier beginning sixty (60) days after it is filed unless the Commissioner disapproves its use.

2. Except as otherwise set forth in this title, the Commissioner at any time may, after providing notice and an opportunity for a hearing to the small employer carrier, disapprove the continued use by a small employer carrier of any health benefit

plan on the grounds that the plan does not meet the requirements of the Small Employer Health Insurance Reform Act.

C. Health benefit plans covering small employers shall comply with the following provisions:

1. A health benefit plan shall not deny, exclude or limit benefits for a covered individual for losses incurred more than twelve (12) months following the effective date of the individual's coverage due to a preexisting condition. A health benefit plan shall not define a preexisting condition more restrictively than:

- a. a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the effective date of coverage, or
- b. a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage;

2. A health benefit plan may exclude coverage for late enrollees for the greater of eighteen (18) months or for an eighteen-month preexisting condition exclusion; provided that if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period shall not exceed eighteen (18) months from the date the individual enrolls for coverage under the health benefit plan;

3.
 - a. Except as provided in subparagraph d of this paragraph, requirements used by a small employer carrier will be limited to requirements for minimum participation of eligible employees and minimum employer contributions. These requirements shall be applied uniformly among all small employers with the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier.
 - b. A small employer carrier may vary application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.
 - c.
 - (1) Except as provided in division (2) of this subparagraph, in applying minimum participation requirements with respect to a small employer, a small employer carrier shall not consider employees or dependents who have qualifying existing coverage in determining whether the applicable percentage of participation is met.
 - (2) With respect to a small employer, a small employer carrier may consider employees or dependents who have coverage under another health

benefit plan sponsored by a small employer in applying minimum participation requirements.

- d. A small employer carrier shall not increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage; and
4. a. If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents. A small employer carrier shall not offer coverage to only certain individuals in a small employer group or to only part of the group, except in the case of late enrollees as provided in paragraph 2 of this subsection.
- b. Except as permitted under paragraphs 1 and 2 of this subsection, a small employer carrier shall not modify a health benefit plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions or services otherwise covered by the plan.

D. The Commissioner shall develop, by rule, a uniform health questionnaire for use by small employers applying for health insurance coverage under group health plans offered by small employer carriers. Small employer carriers shall be required to accept and use the uniform health questionnaire not more than six (6) months after the rules adopting the questionnaire become effective.

E. 1. A small employer carrier shall not be required to offer coverage or accept applications pursuant to subsection A of this section in the case of the following:

- a. to a small employer, where the small employer is not physically located in the established geographic service area of the carrier,
- b. to an employee, when the employee does not work or reside within the established geographic service area of the carrier, or
- c. within an area where the small employer carrier reasonably anticipates, and demonstrates to the satisfaction of the Commissioner, that it will not have the capacity within its established geographic service area to deliver service adequately to the members of such groups because of its obligations to existing group policyholders and enrollees.

2. A small employer carrier that cannot offer coverage pursuant to subparagraph c of paragraph 1 of this subsection may not offer

coverage in the applicable area to new cases of employer groups with more than fifty (50) eligible employees or to any small employer groups until the later of one hundred eighty (180) days following each refusal or the date on which the carrier notifies the Commissioner that it has regained capacity to deliver services to small employer groups.

F. A bona fide association health plan established pursuant to this title to provide benefits to a particular trade, business, profession or industry or their subsidiaries shall not issue coverage to a group or individual that is not in the same trade, business, profession or industry as that covered by the bona fide association health plan. The bona fide association health plan shall accept all employer groups in the same trade, business, profession or industry or their subsidiaries that apply for coverage under the arrangement and that meet the requirements for membership in the arrangement. For purposes of this subsection, the requirements for membership in a bona fide association health plan shall not include any requirements that relate to the actual or expected health status of the prospective enrollee.

Added by Laws 1994, c. 211, § 5, eff. July 1, 1994. Amended by Laws 1998, c. 304, § 4, eff. July 1, 1998; Laws 2010, c. 166, § 1, eff. Nov. 1, 2010; Laws 2012, c. 151, § 3, eff. Nov. 1, 2012.

§36-6520. Repealed by Laws 2010, c. 222, § 64, eff. Nov. 1, 2010.

§36-6521. Repealed by Laws 2010, c. 222, § 64, eff. Nov. 1, 2010.

§36-6522. Repealed by Laws 2021, c. 478, § 42, emerg. eff. May 12, 2021.

§36-6523. Repealed by Laws 2010, c. 222, § 64, eff. Nov. 1, 2010.

§36-6524. Repealed by Laws 1998, c. 304, § 7, eff. July 1, 1998.

§36-6525. Repealed by Laws 2010, c. 222, § 64, eff. Nov. 1, 2010.

§36-6526. Rulemaking.

The Insurance Commissioner may promulgate rules in accordance with Article I of the Administrative Procedures Act, Sections 250.2 through 323 of Title 75 of the Oklahoma Statutes, for the implementation and administration of the Small Employer Health Insurance Reform Act.

Added by Laws 1994, c. 211, § 12, eff. July 1, 1994. Amended by Laws 2010, c. 222, § 46, eff. Nov. 1, 2010.

§36-6527. Marketing of health benefit plan coverage.

A. Each small employer carrier shall actively market health benefit plan coverage to all eligible small employers in this state.

B. 1. Except as provided in paragraph 2 of this subsection, no small employer carrier or agent shall, directly or indirectly, engage in the following activities:

- a. encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status, claims experience, industry, group size, occupation or geographic location of the small employer, or
- b. encouraging or directing small employers to seek coverage from another carrier because of the health status, claims experience, industry, group size, occupation or geographic location of the small employer.

2. The provisions of paragraph 1 of this subsection shall not apply with respect to information provided by a small employer carrier or agent to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.

C. 1. Except as provided in paragraph 2 of this subsection, no small employer carrier shall, directly or indirectly, enter into any contract, agreement or arrangement with an agent that provides for or results in the compensation paid to an agent for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, group size, occupation or geographic location of the small employer.

2. Paragraph 1 of this subsection shall not apply with respect to a compensation arrangement that provides compensation to an agent on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation or geographic area of the small employer.

3. A small employer carrier shall not implement, directly or indirectly, agent commission schedules that vary the level of agent commissions based on the size of the group or otherwise reduce access to small employer health benefit plans.

4. Notwithstanding paragraph 3 of this subsection, a small employer carrier may:

- a. vary agent commission amounts or percentages based on group size if the variation in the commission amounts or percentages are inversely related to the size of the group, or
- b. vary agent commission amounts or percentages based on the cumulative premium paid by a single small employer over a specific period if the variation in the commission amounts or percentages are inversely

related to the cumulative premium paid during the period.

D. A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to an agent, if any, for the sale of any health benefit plan.

E. No small employer carrier may terminate, fail to renew or limit its contract or agreement of representation with an agent for any reason related to the health status, claims experience, occupation, group size, or geographic location of the small employers placed by the agent with the small employer carrier.

F. No small employer carrier or agent may induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.

G. Denial by a small employer carrier of an application for coverage from a small employer shall be in writing and shall state the reason or reasons for the denial. The reasons for denial shall be limited to minimum participation requirements and minimum contribution requirements.

H. The Insurance Commissioner may promulgate rules setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers in this state.

I. 1. A violation of this section by a small employer carrier or an agent shall be an unfair trade practice under Article 12 of this title.

2. If a small employer carrier enters into a contract, agreement or other arrangement with a third-party administrator to provide administrative, marketing or other services related to the offering of health benefit plans to small employers in this state, the third-party administrator shall be subject to this section as if it were a small employer carrier.

Added by Laws 1994, c. 211, § 13, eff. July 1, 1994. Amended by Laws 1998, c. 304, § 6, eff. July 1, 1998; Laws 2001, c. 363, § 27, eff. July 1, 2001.

§36-6528. Reissuance of certain terminated coverage.

The Insurance Commissioner may promulgate rules to require small employer carriers, as a condition of transacting business with small employers in this state after the effective date of this act, to reissue a health benefit plan to any small employer whose health benefit plan has been terminated or not renewed by the carrier after December 31, 1993. The Commissioner may prescribe such terms for the reissue of coverage as the Commissioner finds are reasonable and necessary to provide continuity of coverage to small employers.

Added by Laws 1994, c. 211, § 14, eff. July 1, 1994.

§36-6529. Suspension of implementation if inconsistent with federal law.

In the event that the Congress of the United States enacts laws legally inconsistent with any portion of this act, the Insurance Commissioner may suspend implementation of such inconsistent portion of this act. In such case, the Commissioner shall notify the Governor, President Pro Tempore of the Senate and the Speaker of the House of Representatives.

Added by Laws 1994, c. 211, § 15, eff. July 1, 1994.

§36-6530. Bona fide association health plans.

A. "Bona fide association" means any association that has a current form M-1 filed with and accepted by the United States Department of Labor showing Oklahoma as the state of operation and:

1. Is formed under a pathway established in accordance with the applicable provisions of 29 CFR 2510; or
2. Was previously established or is newly formed under federal regulatory guidance effective prior to August 20, 2018.

B. "Bona fide association health plan" means a health benefit plan that is sponsored by a bona fide association as defined in subsection A of this section.

C. The provisions of the Small Employer Health Insurance Reform Act shall not apply to a health benefit plan issued to a bona fide association health plan.

D. Each bona fide association health plan that meets the requirements of this section shall be considered a large group for purposes of application of the Oklahoma Insurance Code.

E. A bona fide association health plan shall be subject to the following requirements:

1. The bona fide association health plan shall be delivered or issued for delivery to a bona fide association in a form that meets the requirements of Section 4502 of Title 36 of the Oklahoma Statutes;

2. The bona fide association health plan shall comply with any federal nondiscrimination requirement applicable to the association health plan;

3. Small employer groups that have two (2) or more eligible employees and that are members of the association may not be excluded from the association health plan;

4. a. Except as provided in subparagraph b of this paragraph, the association health plan shall maintain an eighty percent (80%) retention rate.

- b. The eighty percent (80%) retention rate specified in subparagraph a of this paragraph shall not include employer groups or working owners that:

- (1) go out of business, whether through merger, acquisition or any other reason,
 - (2) no longer meet eligibility requirements for membership in the association,
 - (3) no longer meet participation requirements for employers that are set forth in the plan documents, or
 - (4) fail to pay premiums.
- c. A bona fide association health plan that fails to maintain the eighty percent (80%) retention rate during any year may have twelve (12) months to correct the retention level before being required to become subject to the requirements of the Small Employer Health Insurance Reform Act.
- d. A bona fide association health plan may not require a contract under this subsection between the bona fide association health plan and the member to be effective for a period of longer than two (2) years. This provision shall not be construed to prevent a contract from being extended for additional two-year periods or preventing the member from voluntarily electing a contract period of longer than two (2) years; and

5. Each bona fide association health plan shall be available to be marketed and sold by all licensed agents and brokers of the health carrier, at the health carrier's standard commission and/or fee schedule for the calendar year.

Added by Laws 2019, c. 265, § 3, eff. Nov. 1, 2019.

§36-6530.1. Oklahoma Individual Health Insurance Market Stabilization Act - Legislative intent.

This act shall be known and may be cited as the "Oklahoma Individual Health Insurance Market Stabilization Act". It is the intent of the Legislature to provide payments to health insurance plans with respect to claims for eligible individuals for the purpose of lowering premiums for health insurance coverage offered in the individual market. Market stabilization activities shall include establishment of a high-risk pool, reinsurance, hybrid programs or any combination thereof. It is the further intent of the Legislature to bestow upon the Oklahoma Insurance Commissioner the authority to appoint a Board of Directors which shall create, implement, oversee and monitor the high-risk pool, reinsurance or hybrid programs under provisions of this act. The Board of Directors and the Oklahoma Secretary of Health and Human Services are authorized to apply for, accept and receive federal funds to implement and sustain market stabilization programs. Preliminary planning and analysis shall continue under the direction of the Oklahoma Insurance Commissioner. The onset of market stabilization

implementation shall be contingent upon Oklahoma's approval for and receipt of federal funds to implement and sustain market stabilization programs.

Added by Laws 2017, c. 383, § 1, emerg. eff. June 6, 2017.

§36-6530.2. Definitions.

As used in the Oklahoma Individual Health Insurance Market Stabilization Act:

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

2. "Board" means the Board of Directors of the Oklahoma Individual Health Insurance Market Stabilization Program;

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

4. "High-risk pool" means specially designated health insurance plans organized by federal or state entities, or a combination of federal and state entities, to serve high-risk, high-cost or both high-risk and high-cost individuals who meet enrollment criteria and do not have access to group insurance. They are organized as independent entities governed by their own boards and administrators and supported by the state's department of insurance;

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

6. "Market" means the individual health insurance market in Oklahoma, wherein income-eligible individuals may receive federal financial assistance for the purchase of qualified health plans as provided by Section 36B of Title 26 of the United States Code and Section 1301 of the federal Patient Protection and Affordable Care Act;

7. "Market stabilization activities" means a high-risk pool, reinsurance, hybrid programs or any combination thereof authorized by this act;

8. "Plan" means any of the comprehensive health insurance benefit plans as approved by the Board of Directors of the Oklahoma Individual Health Insurance Market Stabilization Program or qualified for participation in the market or by rule;

9. "Program" means the Oklahoma Individual Health Insurance Market Stabilization Program;

10. "Reinsurer" means any insurer from whom any insurer providing health insurance to Oklahomans procures insurance for itself with respect to all or part of the health insurance risk of the person; and

11. "Reinsurance" means the contract made between an entity providing insurance coverage and a third party to protect the insurer from losses. The contract provides for the third party to pay for the loss sustained by the insurer when the insurer makes a payment on the original contract. Reinsurance lets insurers cover a portion of their financial risks by recovering some or all of the claimed amounts they pay.

Added by Laws 2017, c. 383, § 2, emerg. eff. June 6, 2017.

§36-6530.3. Eligible persons.

Except as otherwise provided in this section, any person who is qualified for and enrolled in coverage through the market and is a permanent resident of the State of Oklahoma shall be eligible for coverage under the Oklahoma Individual Health Insurance Market Stabilization Program except that:

1. No person who is currently receiving or is entitled to receive health care benefits under any other federal or state program providing financial assistance or preventive and rehabilitative social services is eligible for coverage under the Program; and

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

Added by Laws 2017, c. 383, § 3, emerg. eff. June 6, 2017.

§36-6530.4. Oklahoma Individual Health Insurance Market Stabilization Program.

A. There is hereby created a nonprofit legal entity to be known as the "Oklahoma Individual Health Insurance Market Stabilization Program".

B. 1. The Program shall operate under the management of a nine-member Board of Directors appointed by the Insurance Commissioner. The Board shall consist of:

- a. two representatives of domestic insurance companies licensed to do business in this state,
- b. one member from the general public who is a member of the class of individuals to which the program would apply,
- c. one representative of a health maintenance organization,
- d. one member from a health-related profession,
- e. one member from the general public who is not associated with the medical profession, a hospital or an insurer,
- f. one representative of reinsurers, and
- g. two representatives from the providers of individual plans licensed to do business in this state.

2. The original Board shall be appointed for the following terms:

- a. three members for a term of one (1) year,
- b. three members for a term of two (2) years, and
- c. three members for a term of three (3) years.

3. All terms after the initial term shall be for three (3) years.

4. The Board shall elect one of its members as chairperson.

5. Members of the Board may be reimbursed from monies of the Program for actual and necessary expenses incurred by them in the performance of their official duties as members of the Board but shall not otherwise be compensated for their services.

6. The Board shall adopt a plan of operation and submit its articles, bylaws and operating rules to the Insurance Commissioner for approval. If the Board fails to submit a suitable plan of operation, articles, bylaws and operating rules within one hundred eighty (180) days, then the Insurance Commissioner shall promulgate rules governing the operation of the Program. If the Board subsequently adopts and submits any plan of operation, articles, bylaws or operating rules that are approved by the Commissioner, then the Commissioner shall revoke prior adopted administrative rules that the Commissioner determines to be inconsistent with the approved plan of operation, articles, bylaws or operating rules.

7. The Board shall have the authority to hire an Executive Director of the Program.

8. The Oklahoma Insurance Department shall provide administrative and operational support to the Program and to the Board. The Board shall reimburse the Insurance Commissioner for any direct and actual administrative costs associated with administering the provisions of this act from monies collected by the Board.

C. The Board shall cause an audit to be made of, including, but not limited to, the funds, accounts and fiscal affairs of the Program which shall be prepared by an independent certified public

accountant or a licensed public accountant. One copy of the annual audit shall be filed with the State Auditor and Inspector, and one copy shall be presented to the Board not more than one hundred twenty (120) days following the close of each fiscal year. In the event that a copy of the audit as required by this section is not filed with the State Auditor and Inspector within the time herein provided, the State Auditor and Inspector is authorized to either commence an audit or employ a certified public accountant or licensed public accountant to make the audit herein required at the cost and expense of the Program.

Added by Laws 2017, c. 383, § 4, emerg. eff. June 6, 2017.

§36-6530.5. Board of Directors - Duties - Sunset of Program.

A. The Board of Directors of the Oklahoma Individual Health Insurance Market Stabilization Program shall:

1. Develop, implement and administer the Program.

Implementation of the Program shall be contingent upon Oklahoma's approval for and receipt of federal funds to implement and sustain the Program;

2. Apply for and utilize federal funding for the reinsurance program, as provided in subsection C of this section;

3. Make payments to provide for the market stabilization activities authorized by this act and for administrative expenses incurred or estimated to be incurred during the period for which assessment is made;

4. Establish administrative and accounting processes and procedures for the operation of the Program and create operating rules to effectuate the provisions of this act including but not limited to:

- a. determine eligibility of individuals to receive coverage under the Program,
- b. establish standards for qualification based upon health status, health conditions, prior or current insurance coverage status, health costs as a result of utilization of consuming health care,
- c. establish the dollar amount of claims for eligible individuals after which the Program will provide payments to health insurance plans and the proportion of such claims above such dollar amount that the Program will pay,
- d. establish the rate at which the Program will reimburse a health insurance plan for claims incurred for an enrolled individual's claims, above the attachment point and below the reinsurance cap,
- e. determine the threshold amount for claims costs incurred by a health insurance plan for an enrolled individual's claims, after which the claims costs for

benefits are no longer eligible for reinsurance payments, and

- f. determine the diagnosed health condition of an eligible individual for which the Program will provide payments to health insurance plans for claims incurred after such diagnosis is made; and

5. Apply for, accept and receive federal funding for the operation of the Program, including the following:

- a. approval of a waiver provided by Section 1332 of the Patient Protection and Affordable Care Act, "1332 State Innovation Waiver", authorizing federal funding to support market stabilization program payments,
- b. Oklahoma's participation in any federal grant program or programs, or
- c. any combination of the above approaches.

B. In the event Oklahoma is unable to secure federal approval of a 1332 State Innovation Waiver or secure funding from federal grant programs within two (2) years from the effective date of this act, the Oklahoma Individual Health Insurance Market Stabilization Program shall sunset, and any remaining monies shall be returned to insurers on a pro rata basis based on the amount each insurer has paid in assessments since the creation of the Program.

C. To the extent that federal funds become available under federal law, regulation or executive action, the Board may:

1. Apply for the funds; and

2. Use the funds to establish and administer a reinsurance program for the purposes of the Oklahoma Individual Health Insurance Market Stabilization Act.

D. The Board shall not have the authority to assess insurers, employers, policies or plans or any other entity to fund the program. The Board may accept funding from other sources for the purpose of the Oklahoma Individual Health Insurance Market Stabilization Act.

Added by Laws 2017, c. 383, § 5, emerg. eff. June 6, 2017. Amended by Laws 2018, c. 267, § 1.

§36-6530.6. Board of Directors - Powers.

The Board may:

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

2. Sue or be sued; and

3. Request the Insurance Commissioner to check the reports, records, books and papers of the Insurance Department to determine the financial condition of an insurer for purposes of Section 8 of this act.

Added by Laws 2017, c. 383, § 6, emerg. eff. June 6, 2017. Amended by Laws 2018, c. 267, § 2.

§36-6530.7. Repealed by Laws 2018, c. 267, § 3.

§36-6530.8. Repealed by Laws 2018, c. 267, § 3.

§36-6530.9. Unfair practice - Separating individual employees from group health insurance coverage.

It shall constitute an unfair practice for the purposes of Sections 1201 through 1220 of Title 36 of the Oklahoma Statutes for an insurer, insurance agent, insurance broker or third-party administrator to refer an individual employee to the Program or arrange for an individual employee to apply for the Program, for the purpose of separating that employee from group health insurance coverage provided in connection with the employee's employment. Added by Laws 2017, c. 383, § 9, emerg. eff. June 6, 2017.

§36-6530.10. Application for waiver pursuant to Patient Protection and Affordable Care Act.

The Oklahoma Secretary of Health and Human Services may apply to the United States Secretary of Health and Human Services for a waiver pursuant to Section 1332 of the Patient Protection and Affordable Care Act (42 U.S.C., Section 18052), "1332 State Innovation Waiver", with respect to health insurance coverage in the state for a plan year beginning on or after January 1, 2018. The Secretary may implement a state plan meeting the waiver requirements in a manner consistent with state and federal law and as approved by the United States Secretary of Health and Human Services. Added by Laws 2017, c. 383, § 10, emerg. eff. June 6, 2017.

§36-6531. Repealed by Laws 2014, c. 389, § 3, eff. Jan. 1, 2017.

§36-6532. Repealed by Laws 2014, c. 389, § 3, eff. Jan. 1, 2017.

§36-6533. Repealed by Laws 2014, c. 389, § 3, eff. Jan. 1, 2017.

§36-6534. Repealed by Laws 2014, c. 389, § 3, eff. Jan. 1, 2017.

§36-6535. Repealed by Laws 2014, c. 389, § 3, eff. Jan. 1, 2017.

§36-6536. Repealed by Laws 2014, c. 389, § 3, eff. Jan. 1, 2017.

§36-6537. Repealed by Laws 2014, c. 389, § 3, eff. Jan. 1, 2017.

§36-6538. Repealed by Laws 2014, c. 389, § 3, eff. Jan. 1, 2017.

§36-6538.1. Repealed by Laws 2014, c. 389, § 3, eff. Jan. 1, 2017.

§36-6539. Repealed by Laws 2014, c. 389, § 3, eff. Jan. 1, 2017.

§36-6540. Repealed by Laws 2014, c. 389, § 3, eff. Jan. 1, 2017.

§36-6541. Repealed by Laws 2014, c. 389, § 3, eff. Jan. 1, 2017.

§36-6542. Repealed by Laws 2014, c. 389, § 3, eff. Jan. 1, 2017.

§36-6543. Repealed by Laws 2014, c. 389, § 3, eff. Jan. 1, 2017.

§36-6544. Repealed by Laws 2014, c. 389, § 3, eff. Jan. 1, 2017.

§36-6545. Repealed by Laws 2014, c. 389, § 4, eff. Dec. 1, 2017.

§36-6551. Short title.

Sections 1 through 16 of this act shall constitute a part of the Insurance Code and shall be known and may be cited as the "Hospital and Medical Services Utilization Review Act".

Added by Laws 1991, c. 294, § 1, eff. Nov. 1, 1991.

§36-6552. Definitions.

As used in the Hospital and Medical Services Utilization Review Act:

1. "Utilization review" means a system for prospectively, concurrently and retrospectively reviewing the appropriate and efficient allocation of hospital resources and medical services given or proposed to be given to a patient or group of patients. It does not include an insurer's normal claim review process to determine compliance with the specific terms and conditions of the insurance policy;

2. "Private review agent" means a person or entity who performs utilization review on behalf of:

- a. an employer in this state, or
- b. a third party that provides or administers hospital and medical benefits to citizens of this state, including, but not limited to:

- (1) a health maintenance organization issued a license pursuant to Section 2501 et seq. of Title 63 of the Oklahoma Statutes, unless the health maintenance organization is federally regulated and licensed and has on file with the Insurance Commissioner a plan of utilization review carried out by health care professionals and providing for complaint and appellate procedures for claims, or
- (2) a health insurer, not-for-profit hospital service or medical plan, health insurance service

organization, or preferred provider organization or other entity offering health insurance policies, contracts or benefits in this state;

3. "Utilization review plan" means a description of utilization review procedures;

4. "Commissioner" means the Insurance Commissioner;

5. "Certificate" means a certificate of registration granted by the Insurance Commissioner to a private review agent; and

6. "Health care provider" means any person, firm, corporation or other legal entity that is licensed, certified, or otherwise authorized by the laws of this state to provide health care services, procedures or supplies in the ordinary course of business or practice of a profession.

Added by Laws 1991, c. 294, § 2, eff. Nov. 1, 1991. Amended by Laws 2021, c. 478, § 34, emerg. eff. May 12, 2021.

§36-6553. Private review agents - Certification required - Exemptions.

A. A private review agent who approves or denies payment or who recommends approval or denial of payment for hospital or medical services or whose review results in approval or denial of payment for hospital or medical services on a case-by-case basis shall not conduct utilization review in this state unless the Insurance Commissioner has granted the private review agent a certificate.

B. Except as provided in Section 9 of this act, the Hospital and Medical Services Utilization Review Act shall not apply to any insurance company or not-for-profit hospital service and medical indemnity plan licensed by the Commissioner to transact insurance in this state. If the insurer contracts outside the company for any or all utilization review services, the entity with whom the insurance company contracts shall be subject to all of the provisions of the Hospital and Medical Services Utilization Review Act.

C. The State and Education Employees Group Insurance Board shall be exempt from the provisions of the Hospital and Medical Services Utilization Review Act and regulated accordingly as provided for in the State and Education Employees Group Insurance Act. In addition, the Board shall comply with the provisions of Section 17 of this act. If the State and Education Employees Group Insurance Board contracts for utilization review services instead of having utilization review services be performed by employees of the Board, the entity with whom the Board contracts shall be subject to all of the provisions of the Hospital and Medical Services Utilization Review Act.

Added by Laws 1991, c. 294, § 3, eff. Nov. 1, 1991.

§36-6554. Exemptions - Review of patients eligible under Social Security - In-house utilization review.

A. The Insurance Commissioner shall waive the requirements of the Hospital and Medical Services Utilization Review Act for the activities of a private review agent in connection with a contract with the federal or state government for utilization review of patients eligible for hospital and medical services under the Social Security Act.

B. No certificate is required for those private review agents conducting general in-house utilization review for hospitals, home health agencies, preferred provider organizations, or other managed care entities, clinics, private offices or any other health facility or entity, so long as the review does not result in the approval or denial of payment for hospital or medical services for a particular case. Such general in-house utilization review shall be exempt from all provisions of the Hospital and Medical Services Utilization Review Act.

Added by Laws 1991, c. 294, § 4, eff. Nov. 1, 1991.

§36-6555. Rules - Forms - Issuance of certificate - Reporting requirements - Confidentiality.

A. The Insurance Commissioner may promulgate and adopt rules to implement the provisions of this section.

B. The Commissioner shall develop standardized forms for registration, performing and implementing certification requirements pursuant to the Hospital and Medical Services Utilization Review Act.

C. The Commissioner shall issue a certificate to an applicant that has met all the requirements of the Hospital and Medical Services Utilization Review Act and applicable rules.

D. The Commissioner may establish reporting requirements to:

1. Evaluate, based upon the information furnished pursuant to the provisions of this act, the effectiveness of private review agents; and

2. Determine if the utilization review programs are in compliance with the provisions of the Hospital and Medical Services Utilization Review Act and applicable rules.

E. Any information required by the Commissioner with respect to customers, patients or utilization review procedures of a private review agent shall be held in confidence and shall not be disclosed to the public. However, a patient or a person with financial responsibility for a patient's bill shall be entitled to information and documents relating to them and their claim.

F. A certificate issued pursuant to the Hospital and Medical Services Utilization Review Act is not transferable.

G. No individual conducting utilization review shall be required to be certified if such utilization review is performed within the scope of such person's employment with an entity already certified pursuant to the Hospital and Medical Services Review Act.

Added by Laws 1991, c. 294, § 5, eff. Nov. 1, 1991.

§36-6556. Health insurance plans - Certification or contract with certified private review agent - Exceptions.

Every health insurance plan which proposes to administer a health benefits program that provides for the coverage of hospital and/or medical benefits and the utilization review of those benefits shall:

1. Be certified in accordance with the Hospital and Medical Services Utilization Review Act; or
2. Contract with a private review agent who is certified in accordance with the Hospital and Medical Services Utilization Review Act.

The provisions of this section shall not apply to insurance companies and not-for-profit hospital services and medical indemnity plans, licensed by the Commissioner to transact insurance in this state, that perform in-house utilization review.

Added by Laws 1991, c. 294, § 6, eff. Nov. 1, 1991.

§36-6557. Application for certificate.

A. An applicant for a certificate shall:

1. Submit an application to an Insurance Commissioner; and
2. Pay to the Commissioner an application fee in an amount of Five Hundred Dollars (\$500.00), which shall be sufficient to pay for the administrative cost of the certification program and any other cost associated with carrying out the provisions of the Hospital and Medical Services Utilization Review Act.

B. The application shall:

1. Be on a form approved by the Commissioner and accompanied by any supporting documentation that the Commissioner requires; and
2. Be signed and verified by the applicant.

Added by Laws 1991, c. 294, § 7, eff. Nov. 1, 1991.

§36-6558. Information required to be submitted by private review agents.

In conjunction with an application for a certificate, the private review agent shall submit information that the Insurance Commissioner requires, including, but not limited to:

1. A utilization review plan that includes:
 - a. an adequate summary description of review standards, protocol and procedures to be used in evaluating proposed or delivered hospital and medical care,
 - b. assurances that the standards and criteria to be applied in review determinations are established with input from health care providers representing major areas of specialty and certified by the boards of the various American medical specialties. The entity

shall provide the Commissioner with a list of such representatives and their major areas of specialty upon request, and

- c. the provisions by which patients or health care providers may seek reconsideration or appeal of adverse decisions by the private review agent;

2. The type and qualifications of the personnel either employed or under contract to perform the utilization review;

3. The procedures and policies to ensure that a representative of the private review agent is reasonably accessible, if domiciled in this state, to patients and health care providers five (5) days a week during normal business hours, such procedures and policies to include as a requirement a toll-free telephone number to be available during said business hours; provided, in the alternative, the out-of-state private review agent shall be available or make staff available by toll-free telephone for at least forty (40) hours per week during normal business hours and shall have a telephone system which is capable of accepting or recording incoming telephone calls during other than normal hours, and shall respond to such calls within two (2) working days, if sufficient information is provided to whomever accepts the call or on a recorded message;

4. The policies and procedures to ensure that all applicable state and federal laws to protect the confidentiality of individual medical records are followed;

5. The policies and procedures to verify the identity and authority of personnel performing utilization review by telephone;

6. A copy of the materials designed to inform applicable patients and health care providers of the requirements of the utilization review plan;

7. A list of the third party payors for which the private review agent is performing utilization review in this state. Said list may be deemed confidential by the Commissioner for the purpose of protecting competition between agents;

8. The procedures for receiving and handling complaints by patients and health care providers concerning utilization review; and

9. Procedures to ensure that after a request for medical evaluation, treatment, or procedures has been rejected in whole or in part and in the event a copy of the report on said rejection is requested, a copy of the report of a private review agent concerning the rejection shall be mailed by the insurer, postage prepaid, to the ill or injured person, the treating health care provider or to the person financially responsible for the patient's bill within fifteen (15) days after receipt of the request for the report.

Added by Laws 1991, c. 294, § 8, eff. Nov. 1, 1991.

§36-6559. Information required to be submitted relating to in-house review.

A. Insurance companies and not-for-profit hospital services and medical indemnity plans licensed by the Commissioner that perform in-house utilization review shall submit to the Commissioner the following information regarding utilization review:

1. A utilization review plan that includes:
 - a. an adequate summary description of review standards, protocol and procedures to be used in evaluating proposed or delivered hospital and medical care,
 - b. assurances that the standards and criteria to be applied in review determinations are established with input from health care providers representing major areas of specialty and certified by the boards of the various American medical specialties, and
 - c. the provisions by which patients or health care providers may seek reconsideration or appeal of adverse decisions concerning requests for medical evaluation, treatment or procedures;
2. The type and qualifications of the personnel either employed or under contract to perform the utilization review;
3. The procedures and policies to ensure that a representative is reasonably accessible to patients and health care providers five (5) days a week during normal business hours, such procedures and policies to include as a requirement a toll-free telephone number to be available during said business hours; provided, in the case of insurance companies, if the personnel performing utilization review are out-of-state, the personnel shall be available or make staff available by toll-free telephone for at least forty (40) hours per week during normal business hours and shall have a telephone system which is capable of accepting or recording incoming telephone calls during other than normal hours, and shall respond to such calls within two (2) working days, if sufficient information for response is provided to whomever accepts the call or on a recorded message;
4. The policies and procedures to ensure that all applicable state and federal laws to protect the confidentiality of individual medical records are followed;
5. The policies and procedures to verify the identity and authority of personnel performing utilization review by telephone;
6. A copy of the materials designed to inform applicable patients and health care providers of the requirements of the utilization review plan;
7. The procedures for receiving and handling complaints by patients, hospitals and health care providers concerning utilization review; and
8. Procedures to ensure that after a request for medical evaluation, treatment, or procedures has been rejected in whole or

in part and in the event a copy of the report on said rejection is requested, a copy of the report of the personnel performing utilization review concerning the rejection shall be mailed by the insurer, postage prepaid, to the ill or injured person, the treating health care provider, hospital or to the person financially responsible for the patient's bill within fifteen (15) days after receipt of the request for the report.

B. Insurance companies that provide for in-house utilization review shall pay an annual fee to the Insurance Commissioner of Five Hundred Dollars (\$500.00).

Added by Laws 1991, c. 294, § 9, eff. Nov. 1, 1991.

§36-6560. Expiration of certificate - Renewal.

A. A certificate expires on the first anniversary of its effective date unless the certificate is renewed for a one-year term as provided in this section.

B. Before the certificate expires, a certificate may be renewed for an additional one-year term, if the applicant:

1. Otherwise is entitled to the certificate;
2. Pays the Insurance Commissioner an annual renewal fee in the amount of Five Hundred Dollars (\$500.00);
3. Submits to the Commissioner:
 - a. a renewal application on the form that the Commissioner requires, and
 - b. satisfactory evidence of compliance with any requirement for certificate renewal;
4. Establishes and maintains a complaint system which has been approved by the Commissioner and which provides reasonable procedures for the resolution of written complaints concerning utilization review; and
5. Maintains records of written complaints for five (5) years from the time the complaints are filed and submits to the Commissioner a summary report at such times and in such format as the Commissioner may require.

Added by Laws 1991, c. 294, § 10, eff. Nov. 1, 1991.

§36-6561. Refusal to issue or renew or suspension or revocation of certificate - Hearing - Appeal.

A. The Insurance Commissioner may refuse to issue or renew or may suspend or revoke a certificate if the holder does not comply with performance assurances under this section, violates any provision of the Hospital and Medical Services Utilization Review Act, or violates any rule adopted pursuant thereto.

B. The Commissioner shall deny or refuse to renew a certificate to any applicant if, upon review of the application, the Commissioner finds that the applicant proposing to conduct utilization review does not:

1. Have available the services of a sufficient number of qualified medical professionals supervised by appropriate health care providers to carry out the applicant's utilization review activities. Said sufficiency shall be based on standards and criteria pursuant to the provisions of subparagraph b of paragraph 1 of Section 8 of this act;

2. Meet any applicable rules the Commissioner adopted pursuant to the Hospital and Medical Services Utilization Review Act relating to the qualifications of private review agents or the performance of utilization review; and

3. Provide assurances satisfactory to the Commissioner that:

- a. the procedure and policies of the private review agent shall protect the confidentiality of medical records, and
- b. the review agent shall be reasonably accessible in this state to patients, hospitals and health care providers as required by this act.

C. Before denying, not renewing, or revoking a certificate, the Commissioner shall provide the applicant or certificate holder with reasonable time to supply additional information demonstrating compliance with the requirements of the Hospital and Medical Services Utilization Review Act and the opportunity to request a hearing. If an applicant or certificate holder requests a hearing, the Commissioner shall send a hearing notice and conduct a hearing in accordance with the Administrative Procedures Act.

D. Any person aggrieved by a final decision of the Commissioner in a contested case may appeal the decision as provided for in the Administrative Procedures Act.

Added by Laws 1991, c. 294, § 11, eff. Nov. 1, 1991.

§36-6562. Disclosure or publication of confidential medical information.

A private review agent shall not disclose or publish individual medical records or any other confidential medical information obtained in the performance of utilization review activities without the appropriate procedures for protecting the patient's confidentiality. Provided, however, that nothing in the Hospital and Medical Services Utilization Review Act shall prohibit a private review agent from providing patient information to a third party with whom the private review agent is affiliated, under contract, or for whom the agent is acting.

Added by Laws 1991, c. 294, § 12, eff. Nov. 1, 1991.

§36-6563. Liability - Construction of act.

Nothing in the Hospital and Medical Services Utilization Review Act shall be deemed to reduce or expand the liability of any person

or entity for any actions or activities with respect to utilization review.

Added by Laws 1991, c. 294, § 13, eff. Nov. 1, 1991.

§36-6564. Examination of affairs of private review agent.

Whenever the Insurance Commissioner deems it to be prudent for the benefit of the insureds, health care providers, or insurers, the Commissioner or any person designated by the Commissioner may visit and examine the affairs of any private review agent to determine if the agent is in compliance with the provisions of the Hospital and Medical Services Utilization Review Act or any rules adopted or orders issued pursuant thereto.

Any person or entity examined pursuant to the provisions of the Hospital and Medical Services Utilization Review Act shall pay the proper charges incurred for such examination, including the actual expenses of the Insurance Commissioner or the expenses and compensation of his authorized representative and the expenses and compensation of assistants and examiners employed therein.

Added by Laws 1991, c. 294, § 14, eff. Nov. 1, 1991.

§36-6565. Civil fines.

For any violation of the provisions of the Hospital and Medical Services Utilization Review Act or any rule adopted pursuant thereto, the Insurance Commissioner may, upon notice and hearing, subject a person or entity to a civil fine of not less than One Hundred Dollars (\$100.00) nor more than One Thousand Dollars (\$1,000.00) for each occurrence.

Added by Laws 1991, c. 294, § 15, eff. Nov. 1, 1991.

§36-6566. Repealed by Laws 2009, c. 432, § 27, eff. July 1, 2009.

§36-6570.1. Definitions.

As used in this act:

1. "Adverse determination" means a determination by a health carrier or its designee utilization review entity that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated as defined by Section 6475.3 of Title 36 of the Oklahoma Statutes;

2. "Chronic condition" means a condition that lasts one (1) year or more and requires ongoing medical attention or limits activities of daily living or both;

3. "Clinical criteria" means the written policies, written screening procedures, determination rules, determination abstracts, clinical protocols, practice guidelines, medical protocols, and any other criteria or rationale used by the utilization review entity to determine the necessity and appropriateness of health care services;

4. "Emergency health care services", with respect to an emergency medical condition as defined in 42 U.S.C.A., Section 300gg-111, means:

- a. a medical screening examination, as required under Section 1867 of the Social Security Act, 42 U.S.C., Section 1395dd, or as would be required under such section if such section applied to an independent, freestanding emergency department, that is within the capability of the emergency department of a hospital or of an independent, freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and
- b. within the capabilities of the staff and facilities available at the hospital or the independent, freestanding emergency department, as applicable, such further medical examination and treatment as are required under Section 1395dd of the Social Security Act, or as would be required under such section if such section applied to an independent, freestanding emergency department, to stabilize the patient, regardless of the department of the hospital in which such further examination or treatment is furnished, as defined by 42 U.S.C.A., Section 300gg-111;

5. "Emergency Medical Treatment and Active Labor Act" or "EMTALA" means Section 1867 of the Social Security Act and associated regulations;

6. "Enrollee" means an individual who is enrolled in a health care plan, including covered dependents, as defined by Section 6592.1 of Title 36 of the Oklahoma Statutes;

7. "Health care provider" means any person or other entity who is licensed pursuant to the provisions of Title 59 or Title 63 of the Oklahoma Statutes, or pursuant to the definition in Section 1-1708.1C of Title 63 of the Oklahoma Statutes;

8. "Health care services" means any services provided by a health care provider, or by an individual working for or under the supervision of a health care provider, that relate to the diagnosis, assessment, prevention, treatment, or care of any human illness, disease, injury, or condition, as defined by paragraph 2 of Section 1-1708.1C of Title 63 of the Oklahoma Statutes.

The term also includes the provision of mental health and substance use disorder services, as defined by Section 6060.10 of Title 36 of the Oklahoma Statutes, and the provision of durable medical equipment. The term does not include the provision, administration, or prescription of pharmaceutical products or services;

9. "Licensed mental health professional" means:

- a. a psychiatrist who is a diplomate of the American Board of Psychiatry and Neurology,
- b. a psychiatrist who is a diplomate of the American Osteopathic Board of Neurology and Psychiatry,
- c. a physician licensed pursuant to the Oklahoma Allopathic Medical and Surgical Licensure and Supervision Act or the Oklahoma Osteopathic Medicine Act,
- d. a clinical psychologist who is duly licensed to practice by the State Board of Examiners of Psychologists,
- e. a professional counselor licensed pursuant to the Licensed Professional Counselors Act,
- f. a person licensed as a clinical social worker pursuant to the provisions of the Social Worker's Licensing Act,
- g. a licensed marital and family therapist as defined in the Marital and Family Therapist Licensure Act,
- h. a licensed behavioral practitioner as defined in the Licensed Behavioral Practitioner Act,
- i. an advanced practice nurse as defined in the Oklahoma Nursing Practice Act,
- j. a physician assistant who is licensed in good standing in this state, or
- k. a licensed alcohol and drug counselor/mental health (LADC/MH) as defined in the Licensed Alcohol and Drug Counselors Act;

10. "Medically necessary" means services or supplies provided by a health care provider that are:

- a. appropriate for the symptoms and diagnosis or treatment of the enrollee's condition, illness, disease, or injury,
- b. in accordance with standards of good medical practice,
- c. not primarily for the convenience of the enrollee or the enrollee's health care provider, and
- d. the most appropriate supply or level of service that can safely be provided to the enrollee as defined by Section 6592 of Title 36 of the Oklahoma Statutes;

11. "Notice" means communication delivered either electronically or through the United States Postal Service or common carrier;

12. "Physician" means an allopathic or osteopathic physician licensed by the State of Oklahoma or another state to practice medicine;

13. "Prior authorization" means the process by which utilization review entities determine the medical necessity and medical appropriateness of otherwise covered health care services prior to the rendering of such health care services. The term shall include "authorization", "pre-certification", and any other term that would be a reliable determination by a health benefit plan. The term shall not be construed to include or refer to such processes as they may pertain to pharmaceutical services;

14. "Urgent health care service" means a health care service with respect to which the application of the time periods for making an urgent care determination, which, in the opinion of a physician with knowledge of the enrollee's medical condition:

- a. could seriously jeopardize the life or health of the enrollee or the ability of the enrollee to regain maximum function, or
- b. in the opinion of a physician with knowledge of the claimant's medical condition, would subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review; and

15. "Utilization review entity" means an individual or entity that performs prior authorization for a health benefit plan as defined by Section 6060.4 of Title 36 of the Oklahoma Statutes, but shall not include any health plan offered by a contracted entity defined in Section 4002.2 of Title 56 of the Oklahoma Statutes that provides coverage to members of the state Medicaid program or other insurance subject to the Long-Term Care Insurance Act.

Added by Laws 2024, c. 303, § 2, eff. Jan. 1, 2025.

§36-6570.2. Utilization review entities – Duties.

A utilization review entity shall make any current prior authorization requirements and restrictions, including written clinical criteria, readily accessible on its website to enrollees and health care providers. Prior authorization requirements shall be described in detail but also in easily understandable language.

If a utilization review entity intends either to implement a new prior authorization requirement or restriction, or amend an existing requirement or restriction, the utilization review entity shall ensure that the new or amended requirement or restriction is not implemented unless the utilization review entity's website has been updated to reflect the new or amended requirement or restriction.

If a utilization review entity intends either to implement a new prior authorization requirement or restriction, or amend an existing requirement or restriction, the utilization review entity shall

provide contracted health care providers credentialed to perform the service, or enrollees who have a chronic condition and are already receiving the service for which the prior authorization changes will impact, notice of the new or amended requirement or restriction no less than sixty (60) days before the requirement or restriction is implemented.

Added by Laws 2024, c. 303, § 3, eff. Jan. 1, 2025.

§36-6570.3. Adverse determinations to be made by physician or licensed mental health professional.

A utilization review entity shall ensure that all adverse determinations are made by a physician or licensed mental health professional. The physician or licensed mental health professional shall:

1. Possess a current and valid nonrestricted license in any United States jurisdiction;
2. Have the appropriate training, knowledge, or expertise to apply appropriate clinical guidelines to the health care service being requested; and
3. Make the adverse determination under the clinical direction of one of the utilization review entity's medical directors who is responsible for the provision of reviewing health care services to enrollees of Oklahoma. All such medical directors must be physicians licensed in any United States jurisdiction.

Added by Laws 2024, c. 303, § 4, eff. Jan. 1, 2025.

§36-6570.4. Appeals to be reviewed by physician or licensed mental health professional.

A utilization review entity shall ensure that all appeals are reviewed by a physician or licensed mental health professional. The physician or licensed mental health professional shall:

1. Possess a current and valid unrestricted license in any United States jurisdiction;
2. Be of the same or similar specialty as a physician or licensed mental health professional who typically manages the medical condition or disease, which means that the physician either maintains board certification for the same or similar specialty as the medical condition in question or whose training and experience:
 - a. includes treating the condition,
 - b. includes treating complications that may result from the service or procedure, and
 - c. is sufficient for the physician or licensed mental health professional to determine if the service or procedure is medically necessary or clinically appropriate,

except for appeals coming from a licensed mental health professional, which may be conducted by another licensed mental health professional as opposed to a physician;

3. Not have been directly involved in making the adverse determination;

4. Not have any financial interest in the outcome of the appeal; and

5. Consider all known clinical aspects of the health care service under review, including, but not limited to, a review of those medical records which are pertinent and relevant to the active condition provided to the utilization review entity by the enrollee's health care provider, or a health care facility, and any pertinent medical literature provided to the utilization review entity by the health care provider.

Added by Laws 2024, c. 303, § 5, eff. Jan. 1, 2025.

§36-6570.5. Prior Authorization Application Programming Interface requirement.

A. For plan years beginning on or after January 1, 2027, a health benefit plan must implement and maintain a Prior Authorization Application Programming Interface (API), as described in 45 C.F.R. Part 156.

B. By July 1, 2027, health care providers must have electronic health records or practice management systems that are compatible with the API.

C. As of the effective date of this act, a utilization review entity must provide health care providers with the following opportunities for communication during the prior authorization process:

1. Make staff available at least eight (8) hours a day during normal business hours for inbound telephone calls regarding prior authorization issues;

2. Allow staff to receive inbound communication regarding prior authorization issues after normal business hours; and

3. Provide a treating provider with the opportunity to discuss a prior authorization denial with an appropriate reviewer.

Added by Laws 2024, c. 303, § 6, eff. Jan. 1, 2025.

§36-6570.6. Time frame to make prior authorization or adverse determination.

A. If a utilization review entity requires prior authorization of a health care service, the utilization review entity must make a prior authorization or adverse determination and notify the enrollee and the enrollee's health care provider of the prior authorization or adverse determination in accordance with the time frames set forth below:

1. For purposes of approving prior authorization for urgent health care services, within seventy-two (72) hours of obtaining all necessary information to make the prior authorization or adverse determination; or

2. For purposes of approving prior authorization for non-urgent health care services, within seven (7) days of obtaining all necessary information to make the prior authorization or adverse determination.

For purposes of this section, "necessary information" includes, but is not limited to, the results of any face-to-face clinical evaluation or second opinion that may be required.

B. For those health care providers that submit all necessary information through the utilization review entity's authorized prior authorization system, health care services are deemed authorized if a utilization review entity fails to comply with the deadlines set forth in this section.

C. In the notification to the health care provider that a prior authorization has been approved, the utilization review entity shall include in such notification the duration of the prior authorization or the date by which the prior authorization will expire.

Added by Laws 2024, c. 303, § 7, eff. Jan. 1, 2025.

§36-6570.7. Services not requiring prior authorization – Time frame to notify utilization review entity of such services.

A. A utilization review entity shall not require prior authorization for pre-hospital transportation, for the provision of emergency health care services, or for transfers between facilities as required by the Emergency Medical Treatment and Active Labor Act.

B. A utilization review entity shall allow an enrollee and the enrollee's health care provider a minimum of twenty-four (24) hours following an emergency admission or provision of emergency health care services for the enrollee or health care provider to notify the utilization review entity of the admission or provision of health care services. If the admission or health care service occurs on a holiday or weekend, a utilization review entity cannot require notification until the next business day after the admission or provision of the health care services.

C. A utilization review entity shall cover emergency health care services in accordance with the requirements of Section 6907 of Title 36 of the Oklahoma Statutes.

Added by Laws 2024, c. 303, § 8, eff. Jan. 1, 2025.

§36-6570.8. Time frame in which prior authorization may not be altered – Contracted payment rate requirement and exceptions.

A. A health benefit plan may not revoke, limit, condition, or restrict a prior authorization if care is provided within forty-five (45) business days from the date the health care provider received

the prior authorization unless the enrollee was no longer eligible for care on the day care was provided.

B. A health benefit plan must pay a contracted health care provider at the contracted payment rate for a health care service provided by the health care provider per a prior authorization, unless:

1. The health care provider knowingly and materially misrepresented the health care service in the prior authorization request with the specific intent to deceive and obtain an unlawful payment from a utilization review entity;

2. The health care service was no longer a covered benefit on the day it was provided;

3. The health care provider was no longer contracted with the patient's health benefit plan on the date the care was provided;

4. The health care provider failed to meet the utilization review entity's timely filing requirements; or

5. The patient was no longer eligible for health care coverage on the day the care was provided.

Added by Laws 2024, c. 303, § 9, eff. Jan. 1, 2025.

§36-6570.9. Treatment of chronic conditions – Validity period for prior authorization of inpatient and non-inpatient care.

A. If a prior authorization is required for a health care service, other than for inpatient care, for the treatment of a chronic condition of an enrollee, then the prior authorization shall remain valid for at least six (6) months from the date the health care provider receives the prior authorization approval, unless clinical criteria changes and notice of the change in clinical criteria is provided as stipulated in this act.

B. If a prior authorization is required for inpatient acute care for the treatment of a chronic condition of an enrollee, then the prior authorization shall remain valid for at least fourteen (14) calendar days from the date the health care provider receives the prior authorization approval.

1. If an enrollee requires inpatient care beyond the length of stay that was previously approved by the utilization review entity, then the utilization review entity shall evaluate any prior authorization requests for the continuation of inpatient care according to the provisions of this act. A utilization review entity shall not use any stricter criteria to determine medical necessity and appropriateness of the continuation of inpatient care as the utilization review entity used to evaluate the initial request for authorization of inpatient care. A utilization review entity shall review any relevant and pertinent literature or data provided by the health care provider to determine the medical necessity and appropriateness of the requested length of stay and/or continuation of inpatient care. A prior authorization for the

continuation of inpatient care shall remain valid for a maximum of fourteen (14) calendar days from the date the health care provider receives the prior authorization approval.

2. If a utilization review entity fails to respond to a health care provider's timely prior authorization request for the continuation of inpatient acute care before the termination of the previously approved length of stay, then the health benefit plan shall continue to compensate the health care provider at the contracted rate for inpatient care provided until the utilization review entity issues its determination on the prior authorization request.

For the purposes of this section, a timely request for continuation of inpatient care means a request that is submitted at least seventy-two (72) hours prior to the termination of the previously approved prior authorization and includes all necessary information for the utilization review entity to make a determination.

3. If a utilization review entity issues an adverse determination to a health care provider's prior authorization request for continuation of inpatient acute care and the health care provider appeals the adverse determination according to the provisions of this act, then the health benefit plan shall continue to compensate the health care provider at the contracted rate for inpatient care provided until the appeal has been finalized.

C. This section does not require a health benefit plan to cover care, treatment, or services for a health condition that the terms of coverage otherwise completely exclude from the policy's covered benefits without regard for whether the care, treatment, or services are medically necessary.

Added by Laws 2024, c. 303, § 10, eff. Jan. 1, 2025.

§36-6570.10. Prior authorization granted under former health plan – Time frame to honor – Review.

A. On receipt of information documenting a prior authorization from the enrollee or from the enrollee's health care provider, a utilization review entity shall honor a prior authorization granted to an enrollee from a previous utilization review entity for at least the initial sixty (60) days of an enrollee's coverage under a new health plan.

B. During the time period described in subsection A of this section, a utilization review entity may perform its own review to grant a prior authorization or make an adverse determination.

C. A utilization review entity shall continue to honor a prior authorization it has granted to an enrollee when the enrollee changes products under the same health insurance company for the initial sixty (60) days of an enrollee's coverage under the new

product unless the service is no longer a covered service under the new product.

Added by Laws 2024, c. 303, § 11, eff. Jan. 1, 2025.

§36-6570.11. Severability.

If any provision of this act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end, the provisions of this act are declared to be severable.

Added by Laws 2024, c. 303, § 12, eff. Jan. 1, 2025.

§36-6571. Determination of average area or customary and reasonable charges - Disclosure to health care provider of information used.

A. As used in this section:

1. "Health care provider" means any person, firm, corporation or other legal entity that is licensed, certified or otherwise authorized by the laws of this state to provide health care services, procedures or supplies in the ordinary course of business or practice of a profession; and

2. "Insurer" means any insurance company, not-for-profit hospital service and medical indemnity plan, health insurance service organization, preferred provider organization or other entity offering health insurance policies, contracts or benefits in this state.

B. Any insurer which:

1. Makes a determination or contracts with a third party who makes the determination of average area charges or customary and reasonable charges for health care services, procedures or supplies; and

2. Based on such determination, authorizes payment in an amount which is less than the amount charged by the health care provider for such services, procedures or supplies; shall, upon the request of a health care provider, furnish the name, mailing address and telephone number of the party making the determination to the health care provider.

C. Upon the request of the health care provider, the party shall furnish, for a reasonable charge, information used to determine the average area charges or customary and reasonable charges for the services, procedures or supplies provided by the health care provider and authorized for payment pursuant to paragraph 2 of subsection B of this section. The information shall include the rationale and documentation of sources used in the determination of the average area charges or customary and reasonable charges for the services, procedures or supplies in question, including names, mailing addresses and telephone numbers of sources if available. Such information shall be furnished to the

health care provider no later than ten (10) working days after the request for information by the health care provider.

D. 1. No insurer shall use the services of a party for the determination of average area charges or customary and reasonable charges which is not in compliance with the provisions of this section.

2. Noncompliance shall be reported to the Insurance Commissioner who, upon investigation of the complaint and determination that the party is in noncompliance and that no resolution of the complaint will be made within a reasonable time, shall compile and maintain a list of parties which are not in compliance with the provisions of this section.

Added by Laws 1992, c. 297, § 1, eff. Sept. 1, 1992.

§36-6581. Uniform health claim forms - Uniform billing forms - Rules.

A. On or before January 1, 1994, the Insurance Commissioner shall develop and adopt:

1. Uniform health care claim forms for use by all health care providers and carriers in the state; and

2. Uniform standards and procedures for processing such claim forms in electronic and hard-copy form.

The Commissioner shall direct all insurers licensed in the state to begin using the uniform claim forms by July 1, 1994.

B. The Commissioner shall adopt the health care financing administration (HCFA) 1500 form for outpatient billing and claim submission, or its successor, and the uniform billing (UB) 92 form for hospital billing and claim submission, or its successor as the uniform health care claim and billing form for appropriate hospital and medical expenses, and shall develop uniform forms for other health care provider services, including but not limited to pharmacy and dental services.

C. The Commissioner shall promulgate such rules as are necessary for developing, adopting and administering the uniform claim forms and processing system.

Added by Laws 1993, c. 304, § 1, emerg. eff. June 7, 1993. Amended by Laws 1995, c. 246, § 2, eff. Nov. 1, 1995.

§36-6591. Short title - Declaration of necessity.

A. Sections 1 through 6 of this act shall be known and may be cited as the "Managed Health Care Reform and Accountability Act".

B. The Legislature hereby declares that the public good and the general welfare of the citizens of this state require the enactment of this measure under the police power of the state as part of and in furtherance of the regulation of the business of insurance.

Added by Laws 2000, c. 163, § 1, eff. July 1, 2000.

§36-6592. Definitions.

For purposes of this act:

1. "Enrollee" means an individual who is enrolled in a health care plan, including covered dependents;
2. "Health care plan" means any arrangement whereby any person undertakes to provide, arrange for, pay for, or reimburse any part of the costs of any health care services for an enrollee;
3. "Health care provider" means a physician, hospital, pharmaceutical company, pharmacy, pharmacist, laboratory, or other state-licensed or state-recognized provider of health care services;
4. "Health insurance carrier" means an insurance company that issues policies of accident and health insurance and is or should be licensed to sell insurance in this state;
5. "Health maintenance organization" means an organization which is or should be licensed by the State Department of Health pursuant to Section 2501 et seq. of Title 63 of the Oklahoma Statutes;
6. "Managed care entity" means any entity which is a health care plan, health insurance carrier or health maintenance organization as defined in this section, but does not include an employer that sponsors or participates in a health care plan or purchases coverage or assumes risk on behalf of or for the benefit of its employees or the employees of one or more subsidiaries or affiliates of the employer; and
7. "Medically necessary" means services or supplies provided by a health care provider that are:
 - a. appropriate for the symptoms and diagnosis or treatment of the enrollee's condition, illness, disease, or injury,
 - b. in accordance with standards of good medical practice,
 - c. not primarily for the convenience of the enrollee or the enrollee's health care provider, and
 - d. the most appropriate supply or level of service that can safely be provided to the enrollee.

Added by Laws 2000, c. 163, § 2, eff. July 1, 2000.

§36-6593. Duty of health care entity to exercise ordinary care - Liability for damages - Application of act.

A. A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan has the duty to exercise ordinary care when making health care treatment decisions and shall be liable for damages for harm to an enrollee proximately caused by breach of the duty to exercise ordinary care if:

1. The failure to exercise ordinary care resulted in the denial, significant delay, or modification of the health care service recommended for, or furnished to, an enrollee; and
2. The enrollee suffered harm.

B. The standards in subsection A of this section create no obligation on the part of the health insurance carrier, health maintenance organization, or other managed care entity to provide to an enrollee treatment which is not covered by the health care plan.

C. This act does not create any liability on the part of an employer or an employer group purchasing organization that sponsors or participates in a health care plan or purchases coverage or assumes risk on behalf of or for the benefit of its employees or the employees of one or more subsidiaries or affiliates of the employer.

D. A health care plan, health insurance carrier, health maintenance organization, or managed care entity may not remove a health care provider from its plan or refuse to renew the health care provider from its plan for advocating on behalf of an enrollee for appropriate and medically necessary health care for the enrollee.

E. A health insurance carrier, health maintenance organization, or other managed care entity shall not seek indemnification from a health care provider, whether contractual or equitable, for liability imposed by this act. Any provision in a contract to the contrary is void and unenforceable.

F. Nothing in any law of this state prohibiting a health insurance carrier, health maintenance organization, or other managed care entity from practicing medicine or being licensed to practice medicine may be asserted as a defense by a health insurance carrier, health maintenance organization, or other managed care entity in an action brought against it pursuant to this section or any other law of this state.

G. This section shall not create any new or additional liability on the part of a health insurance carrier, health maintenance organization, or managed care entity for harm caused that is attributable to the medical negligence of a health care provider.

H. An enrollee who files an action under this act shall comply with all requirements relating to cost bonds, deposits, and expert reports.

I. This act shall not apply to insurance agents licensed by the Insurance Department.

J. This act shall not apply to workers' compensation insurance. Added by Laws 2000, c. 163, § 3, eff. July 1, 2000.

§36-6594. Prerequisites to maintaining cause of action - Exhaustion of appeal and review process and all applicable remedies - Notice.

A. A person may not maintain a cause of action under this act against a health insurance carrier, health maintenance organization, or other managed care entity unless the affected enrollee or the representative of the enrollee, has exhausted any appeal and review process applicable under the utilization review requirements of the

plan, has exhausted all applicable remedies specified in the Oklahoma Managed Care External Review Act and gives written notice of the claim as provided in subsection B of this section.

B. The notice required by subsection A of this section shall be delivered or mailed to the health insurance carrier, health maintenance organization, or managed care entity against whom the action will be brought at least thirty (30) days before the action is filed.

C. If the enrollee or the representative of the enrollee has not exhausted the appeal and review processes and gives notice as required by subsection A of this section before the statute of limitations applicable to a claim against a managed care entity has expired, the limitations period is tolled until thirty (30) days after the date the enrollee or the representative of the enrollee has exhausted the processes for appeal and review pursuant to subsection A of this section.

Added by Laws 2000, c. 163, § 4, eff. July 1, 2000.

§36-6595. Class action.

No cause of action brought pursuant to this act shall be certified as a class action.

Added by Laws 2000, c. 163, § 5, eff. July 1, 2000.

§36-6596. Application of Section 9.1 of Title 23 to cause of action brought under act.

Subparagraph c of paragraph 2 of subsection C of Section 9.1 of Title 23 of the Oklahoma Statutes shall not apply to any cause of action brought under the Managed Health Care Reform and Accountability Act.

Added by Laws 2000, c. 163, § 6, eff. July 1, 2000.

§36-6601. Repealed by Laws 2012, c. 150, § 39, eff. Nov. 1, 2012.

§36-6602. Repealed by Laws 2012, c. 150, § 39, eff. Nov. 1, 2012.

§36-6603. Repealed by Laws 2012, c. 150, § 39, eff. Nov. 1, 2012.

§36-6604. Repealed by Laws 2012, c. 150, § 39, eff. Nov. 1, 2012.

§36-6605. Repealed by Laws 2012, c. 150, § 39, eff. Nov. 1, 2012.

§36-6606. Repealed by Laws 2008, c. 353, § 29, eff. July 1, 2009.

§36-6607. Repealed by Laws 2012, c. 150, § 39, eff. Nov. 1, 2012.

§36-6608. Repealed by Laws 2012, c. 150, § 39, eff. Nov. 1, 2012.

NOTE: Prior to repeal, this section was amended by Laws 2012, c. 44, § 17 to read as follows:

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 6605 of this 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. 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 as required pursuant to Section 6604 of this 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 the refusal, setting forth the grounds of the refusal.

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 audited financial statements and other information as requested by the Commissioner by May 1, 2010, and each year thereafter, to document and verify that the contracts of the entity are not included within the definition of service warranty.

2. Any entity that fails to meet the May 1 deadline or that begins claiming an exclusion exemption provided by paragraph 14 of Section 6602 of this title after May 1 shall file audited 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 audited 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, SEC filings, audited financial statements of affiliates, and organizational data and organizational charts.

§36-6609. Repealed by Laws 2012, c. 150, § 39, eff. Nov. 1, 2012.

§36-6610. Repealed by Laws 2012, c. 150, § 39, eff. Nov. 1, 2012.

- §36-6611. Repealed by Laws 2012, c. 150, § 39, eff. Nov. 1, 2012.
- §36-6612. Repealed by Laws 2012, c. 150, § 39, eff. Nov. 1, 2012.
- §36-6613. Repealed by Laws 2012, c. 150, § 39, eff. Nov. 1, 2012.
- §36-6614. Repealed by Laws 2012, c. 150, § 39, eff. Nov. 1, 2012.
- §36-6615. Repealed by Laws 2012, c. 150, § 39, eff. Nov. 1, 2012.
- §36-6616. Repealed by Laws 2012, c. 150, § 39, eff. Nov. 1, 2012.
- §36-6617. Repealed by Laws 2012, c. 150, § 39, eff. Nov. 1, 2012.
- §36-6618. Repealed by Laws 2012, c. 150, § 39, eff. Nov. 1, 2012.
- §36-6619. Repealed by Laws 2009, c. 189, § 10, eff. July 1, 2009.
- §36-6620. Repealed by Laws 2012, c. 150, § 39, eff. Nov. 1, 2012.
- §36-6621. Repealed by Laws 2002, c. 460, § 45, eff. Nov. 1, 2002.
- §36-6622. Repealed by Laws 2009, c. 189, § 10, eff. July 1, 2009.
- §36-6623. Repealed by Laws 2009, c. 189, § 10, eff. July 1, 2009.
- §36-6624. Repealed by Laws 2009, c. 189, § 10, eff. July 1, 2009.
- §36-6625. Repealed by Laws 2009, c. 189, § 10, eff. July 1, 2009.
- §36-6626. Repealed by Laws 2012, c. 150, § 39, eff. Nov. 1, 2012.
- §36-6627. Repealed by Laws 2012, c. 150, § 39, eff. Nov. 1, 2012.
- §36-6628. Repealed by Laws 2012, c. 150, § 39, eff. Nov. 1, 2012.
- §36-6629. Repealed by Laws 2012, c. 150, § 39, eff. Nov. 1, 2012.
- §36-6630. Repealed by Laws 2012, c. 150, § 39, eff. Nov. 1, 2012.
- §36-6631. Repealed by Laws 2012, c. 150, § 39, eff. Nov. 1, 2012.
- §36-6632. Repealed by Laws 2012, c. 150, § 39, eff. Nov. 1, 2012.
- §36-6633. Repealed by Laws 2012, c. 150, § 39, eff. Nov. 1, 2012.
- §36-6634. Repealed by Laws 2012, c. 150, § 39, eff. Nov. 1, 2012.

§36-6635. Repealed by Laws 2012, c. 150, § 39, eff. Nov. 1, 2012.

§36-6636. Repealed by Laws 2012, c. 150, § 39, eff. Nov. 1, 2012.

§36-6637. Repealed by Laws 2012, c. 150, § 39, eff. Nov. 1, 2012.

§36-6638. Repealed by Laws 2012, c. 150, § 39, eff. Nov. 1, 2012.

§36-6639. Repealed by Laws 2012, c. 150, § 39, eff. Nov. 1, 2012.

§36-6650. Short title.

Sections 2 through 13 of this act shall be known and may be cited as the "Vehicle Protection Product Act".

Added by Laws 2008, c. 353, § 2, eff. Jan. 1, 2009.

§36-6651. Definitions.

As used in the Vehicle Protection Product Act:

1. "Administrator" means a third party other than the warrantor who is designated by the warrantor to be responsible for the administration of vehicle protection product warranties;

2. "Commissioner" means the Insurance Commissioner;

3. "Department" means the Insurance Department;

4. "Incidental costs" means expenses specified in the warranty incurred by the warranty holder related to the failure of the vehicle protection product to perform as provided in the warranty. Incidental costs may include insurance policy deductibles, rental vehicle charges, the difference between the actual value of the stolen vehicle at the time of theft and the cost of a replacement vehicle, vehicle excise taxes, vehicle registration fees, certificate of title fees, transaction fees and mechanical inspection fees;

5. "Service contract" means a contract or agreement as defined under the Service Warranty Act in Title 15 of the Oklahoma Statutes;

6. "Vehicle protection product" means a vehicle protection device, system, or service that:

a. is installed on or applied to a vehicle,

b. is designed to prevent loss or damage to a vehicle from a specific cause, and

c. includes a written warranty.

For purposes of this section, the term vehicle protection product shall include alarm systems, body part marking products, steering locks, window etch products, pedal and ignition locks, fuel and ignition kill switches, and electronic, radio and satellite tracking devices;

7. "Vehicle protection product warranty" or "warranty" means a written agreement by a warrantor that provides if the vehicle

protection product fails to prevent loss or damage to a vehicle from a specific cause, that the warrantor will pay to or on behalf of the warranty holder specified incidental costs as a result of the failure of the vehicle protection product to perform pursuant to the terms of the warranty;

8. "Vehicle protection product warrantor" or "warrantor" means a person who is contractually obligated to the warranty holder under the terms of the vehicle protection product warranty agreement. Warrantor does not include an authorized insurer providing a warranty reimbursement insurance policy;

9. "Warranty holder" means a person who purchases a vehicle protection product or who is a permitted transferee; and

10. "Warranty reimbursement insurance policy" means a policy of insurance that is issued to the vehicle protection product warrantor to provide reimbursement to the warrantor or to pay on behalf of the warrantor all covered contractual obligations incurred by the warrantor under the terms and conditions of the insured vehicle protection product warranties issued by the warrantor.

Added by Laws 2008, c. 353, § 3, eff. Jan. 1, 2009. Amended by Laws 2012, c. 150, § 34, eff. Nov. 1, 2012; Laws 2014, c. 418, § 5, eff. Nov. 1, 2014.

§36-6652. Compliance with act.

A. No vehicle protection product may be sold or offered for sale in this state unless the seller, warrantor and administrator, if any, comply with the provisions of the Vehicle Protection Product Act.

B. Vehicle protection product warrantors and related vehicle protection product sellers and warranty administrators complying with the Vehicle Protection Product Act are not required to comply with and are not subject to any other provisions of the Oklahoma Insurance Code.

C. Licensed service contract providers may sell motor vehicle ancillary protection products under the Service Warranty Act in Title 15 of the Oklahoma Statutes and such sales shall not be subject to the requirements of the Vehicle Protection Product Act. Licensed service contract providers may also be registered under the Vehicle Protection Product Act. Sales of the vehicle protection products under the Vehicle Protection Product Act are exempt from the requirements of the Service Warranty Act.

D. Warranties, indemnity agreements and guarantees that are not provided as a part of a vehicle protection product are not subject to the provisions of the Vehicle Protection Product Act.

Added by Laws 2008, c. 353, § 4, eff. Jan. 1, 2009. Amended by Laws 2012, c. 150, § 35, eff. Nov. 1, 2012; Laws 2014, c. 418, § 6, eff. Nov. 1, 2014; Laws 2024, c. 345, § 16, eff. Nov. 1, 2024.

§36-6653. Warrantor registration.

A. A person may not operate as a warrantor or represent to the public that the person is a warrantor unless the person is registered with the Insurance Department on a form prescribed by the Insurance Commissioner.

B. Warrantor registration records shall be filed annually and shall be updated within thirty (30) days of any change. The registration records shall contain the following information:

1. The warrantor's name, any fictitious names under which the warrantor does business in the state, principal office address, and telephone number;

2. The name and address of the warrantor's agent for service of process in the state if other than the warrantor;

3. The names of the warrantor's executive officer or officers directly responsible for the warrantor's vehicle protection product business;

4. The name, address, and telephone number of any administrators designated by the warrantor to be responsible for the administration of vehicle protection product warranties in this state;

5. A copy of the warranty reimbursement insurance policy or policies or other financial information required by Section 6 of this act;

6. A copy of each warranty the warrantor proposes to use in this state; and

7. A statement indicating under which provision of Section 6 of this act the warrantor qualified to do business in this state as a warrantor.

C. The Commissioner may charge each registrant a reasonable fee to offer the cost of processing the registration and maintaining the records in an amount to be set by rule. The information in paragraphs 1 and 2 of subsection B of this section shall be made available to the public.

D. If a registrant fails to register by the renewal deadline, the Commissioner shall give the registrant written notice of the failure and the registrant will have thirty (30) days to complete the renewal of registration before the registrant is suspended from being registered in this state.

E. An administrator or person who sells or solicits a sale of a vehicle protection product but who is not a warrantor shall not be required to register as a warrantor or be licensed under the insurance laws of this state to sell vehicle protection products. Added by Laws 2008, c. 353, § 5, eff. Jan. 1, 2009.

§36-6654. Financial security requirements for sales of products.

No vehicle protection product shall be sold or offered for sale in this state unless the warrantor meets the conditions specified in

either paragraph 1 or 2 of this section in order to ensure adequate performance under the warranty. No other financial security requirements or financial standards for warrantors shall be required.

1. The vehicle protection product warrantor is insured under a warranty reimbursement policy issued by an insurer authorized to do business in this state which provides that:

- a. the insurer will pay to, or on behalf of, the warrantor one hundred percent (100%) of all sums that the warrantor is legally obligated to pay according to the warrantor's contractual obligations under the warrantor's vehicle protection product warranty,
- b. a true and correct copy of the warranty reimbursement insurance policy has been filed with the Insurance Commissioner by the warrantor, and
- c. the policy contains the provision required in Section 7 of this act.

2.
 - a. The vehicle protection product warrantor, or its parent company in accordance with subparagraph b of this paragraph, maintains a net worth or stockholders' equity of Fifty Million Dollars (\$50,000,000.00), and
 - b. the warrantor provides the Commissioner with a copy of the warrantor's or the warrantor's parent company's most recent Form 10-K or Form 20-F filed with the Securities and Exchange Commission within the last calendar year or, if the warrantor does not file with the Securities and Exchange Commission, a copy of the warrantor or the warrantor's parent company's audited financial statements that shows a net worth of the warrantor or its parent company of at least Fifty Million Dollars (\$50,000,000.00). If the warrantor's parent company's Form 10-K, Form 20-F, or audited financial statements are filed to meet the warrantor's financial stability requirement, then the parent company shall agree to guarantee the obligations of the warrantor relating to warranties issued by the warrantor in this state. The financial information filed under this subparagraph shall be confidential as a trade secret of the entity filing the information and not subject to public disclosure.

Added by Laws 2008, c. 353, § 6, eff. Jan. 1, 2009.

§36-6655. Warranty reimbursement insurance policy requirements.

No warranty reimbursement insurance policy shall be issued, sold, or offered for sale in this state unless the policy meets the conditions set forth in this section and the Insurance Commissioner has not disapproved the policy.

1. The policy states that the issuer of the policy shall reimburse or pay on behalf of the vehicle protection product warrantor all covered sums which the warrantor is legally obligated to pay or shall provide all service that the warrantor is legally obligated to perform according to the warrantor's contractual obligations under the provisions of the insured warranties issued by the warrantor.

2. The policy states that in the event payment due under the terms of the warranty is not provided by the warrantor within sixty (60) days after proof of loss has been filed according to the terms of the warranty by the warranty holder, the warranty holder may file directly with the warranty reimbursement insurance company for reimbursement.

3. The policy provides that a warranty reimbursement insurance company that insures a warranty shall be deemed to have received payment of the premium if the warranty holder paid for the vehicle protection product and the insurer's liability under the policy shall not be reduced or relieved by a failure of the warrantor, for any reason, to report the issuance of a warranty to the insurer.

4. The policy has the following provisions regarding cancellation of the policy:

- a. the issuer of a reimbursement insurance policy shall not cancel such policy until a notice of cancellation in writing has been mailed or delivered to the Insurance Commissioner and each insured warrantor,
- b. the cancellation of a reimbursement insurance policy shall not reduce the issuer's responsibility for vehicle protection products sold prior to the date of cancellation, and
- c. in the event an insurer cancels a policy that a warrantor has filed with the Commissioner, the warrantor shall do either of the following:
 - (1) file a copy of a new policy with the Commissioner, before the termination of the prior policy, providing no lapse in coverage following the termination of the prior policy, and
 - (2) discontinue offering warranties as of the termination date of the policy until a new policy becomes effective and is accepted by the Commissioner.

Added by Laws 2008, c. 353, § 7, eff. Jan. 1, 2009.

§36-6656. Vehicle protection product warranty requirements -
Incidental costs.

A. Any vehicle protection product shall not be sold or offered for sale in this state unless the warranty:

1. States, "The obligations of the warrantor to the warranty holder are guaranteed under a warranty reimbursement insurance policy", if the warrantor elects to meet its financial responsibility obligations under paragraph 1 of Section 6 of this act, or states, "The obligations of the warrantor under this warranty are backed by the full faith and credit of the warrantor", if the warrantor elects to meet its financial responsibility obligations under paragraph 2 of Section 6 of this act;

2. States that in the event a warranty holder must make a claim against a party other than the warranty reimbursement insurance policy issuer, the warranty holder is entitled to make a direct claim against the insurer upon the failure of the warrantor to pay any claim or meet any obligation under the terms of the warranty within sixty (60) days after proof of loss has been filed with the warrantor, if the warrantor elects to meet its financial responsibility obligations under paragraph 1 of Section 6 of this act;

3. States the name and address of the issuer of the warranty reimbursement insurance policy, and this information need not be preprinted on the warranty form, but may be added to or stamped on the warranty, if the warrantor elects to meet its financial responsibility obligations under paragraph 1 of Section 6 of this act;

4. Identifies the warrantor, the seller, and the warranty holder;

5. Sets forth the total product purchase price and the terms under which it is to be paid; however, the purchase price is not required to be preprinted on the vehicle protection product warranty and may be negotiated with the consumer at the time of sale;

6. Sets forth the procedure for making a claim, including a telephone number;

7. Specifies the payments or performance to be provided under the warranty including payments for incidental costs, the manner of calculation or determination of payments or performance, and any limitations, exceptions or exclusions;

8. Sets forth all of the obligations and duties of the warranty holder, such as the duty to protect against any further damage to the vehicle, the obligation to notify the warrantor in advance of any repair, or other similar requirements, if any;

9. Sets forth any terms, restrictions, or conditions governing transferability and cancellation of the warranty, if any; and

10. Contains a disclosure that reads substantially as follows: "This agreement is a product warranty and is not insurance."

B. Incidental costs may be reimbursed under the provisions of the warranty in either a fixed amount specified in the warranty or sales agreement or by the use of a formula itemizing specific incidental costs incurred by the warranty holder.

Added by Laws 2008, c. 353, § 8, eff. Jan. 1, 2009.

§36-6657. Use of certain terms and names restricted - Vehicle protection product purchase as condition of financing prohibited.

A. Unless licensed as an insurance company, a vehicle protection product warrantor shall not use in its name, contracts, or literature, any of the words "insurance", "casualty", "surety", "mutual", or any other words descriptive of the insurance, casualty, or surety business or deceptively similar to the name or description of any insurance or surety corporation, or any other vehicle protection product warrantor. A warrantor may use the term "guaranty" or similar word in the warrantor's name.

B. A vehicle protection product seller or warrantor may not require as a condition of financing that a retail purchaser of a motor vehicle purchase a vehicle protection product.

Added by Laws 2008, c. 353, § 9, eff. Jan. 1, 2009.

§36-6658. Transaction records - Contents - Retention period - Availability for examination.

A. All vehicle protection product warrantors shall keep accurate accounts, books, and records concerning transactions regulated under the Vehicle Protection Product Act.

B. A vehicle protection product warrantor's accounts, books, and records shall include:

1. Copies of all vehicle protection product warranties;
2. The name and address of each warranty holder; and
3. The dates, amounts, and descriptions of all receipts, claims, and expenditures.

C. A vehicle protection product warrantor shall retain all required accounts, books, and records pertaining to each warranty holder for at least three (3) years after the specified period of coverage has expired. A warrantor discontinuing business in this state shall maintain its records until it furnishes the Insurance Commissioner satisfactory proof that the warrantor has discharged all obligations to warranty holders in this state.

D. Vehicle protection product warrantors shall make all accounts, books, and records concerning transactions regulated under the Vehicle Protection Product Act available to the Commissioner for examination.

Added by Laws 2008, c. 353, § 10, eff. Jan. 1, 2009.

§36-6659. Examination and enforcement by Commissioner - Notice and hearing - Civil penalty.

A. The Insurance Commissioner may conduct examinations of warrantors, administrators, or other persons to enforce the Vehicle Protection Product Act and protect warranty holders in this state. Upon request of the Commissioner, a warrantor shall make available

for the Commissioner all accounts, books, and records concerning vehicle protection products sold by the warrantor that are necessary to enable the Commissioner to reasonably determine compliance or noncompliance with the Vehicle Protection Product Act. The examination shall be conducted pursuant to Sections 309.1 through 309.7 of Title 36 of the Oklahoma Statutes.

B. The Commissioner may take action that is necessary or appropriate to enforce the provisions of the Vehicle Protection Product Act and the Commissioner's rules and orders and to protect warranty holders in this state. If a warrantor engages in a pattern or practice of conduct that violates the Vehicle Protection Product Act and that the Commissioner reasonably believes threatens to render the warrantor insolvent or cause irreparable loss or injury to the property or business of any person or company located in this state, the Commissioner may:

1. Issue an order directed to that warrantor to cease and desist from engaging in further acts, practices, or transactions that are causing the conduct;

2. Issue an order prohibiting that warrantor from selling or offering for sale vehicle protection products in violation of the Vehicle Protection Product Act;

3. Issue an order imposing a civil penalty on that warrantor;

or

4. Issue any combination of the foregoing, as applicable.

C. Prior to the effective date of any order issued pursuant to this section, the Commissioner must provide written notice of the order to the warrantor and the opportunity for a hearing to be set within ten (10) business days after receipt of the notice, except prior notice and hearing shall not be required if the Commissioner reasonably believes that the warrantor has become, or is about to become, insolvent.

D. A person aggrieved by an order issued under this section may request a hearing before the Commissioner. The hearing request shall be filed with the Commissioner within twenty (20) days after the date the Commissioner's order is effective, and the Commissioner must set such a hearing within fifteen (15) days after the receipt of the hearing request.

E. At the hearing, the burden shall be on the Commissioner to show why the order issued pursuant to this section is justified. The provisions of the Administrative Procedures Act shall apply to a hearing request under this section.

F. The Commissioner may bring an action in any court of competent jurisdiction for an injunction or other appropriate relief to enjoin threatened or existing violations of the Vehicle Protection Product Act or of the Commissioner's orders or rules. An action filed under this section also may seek restitution on behalf

of persons aggrieved by a violation of the Vehicle Protection Product Act or orders or rules of the Commissioner.

G. A person who is found to have violated provisions of the Vehicle Protection Product Act or orders or rules of the Commissioner may be ordered to pay to the Commissioner a civil penalty in an amount, determined by the Commissioner, of not more than Five Hundred Dollars (\$500.00) per violation and not more than Ten Thousand Dollars (\$10,000.00) in the aggregate for all violations of a similar nature. For purposes of this section, violations shall be of a similar nature if the violation consists of the same or similar course of conduct, action, or practice, irrespective of the number of times the conduct, action, or practice that is determined to be a violation of the Vehicle Protection Product Act occurred.

Added by Laws 2008, c. 353, § 11, eff. Jan. 1, 2009.

§36-6660. Promulgation of rules.

The Commissioner may promulgate rules consistent with the provisions of the Vehicle Protection Product Act as are necessary to implement them. Such rules shall include disclosures for the benefit of the warranty holder, record-keeping, and procedures for public complaints. These rules may also include the conditions under which surplus lines insurers may be rejected for the purpose of underwriting vehicle protection product warranty agreements.

Added by Laws 2008, c. 353, § 12, eff. Jan. 1, 2009.

§36-6661. Application and construction of act.

The Vehicle Protection Product Act applies to all vehicle protection products sold or offered for sale on or after the effective date of this act. The failure of any person to comply with the Vehicle Protection Product Act prior to its effective date shall not be admissible in any court proceeding, administrative proceeding, arbitration, or alternative dispute resolution proceeding and may not otherwise be used to prove that the action of any person or the affected vehicle protection product was unlawful or otherwise improper. The adoption of the Vehicle Protection Product Act does not imply that a vehicle protection product warranty was insurance prior to the effective date of this act. Nothing in this section shall be construed to require the application of the penalty provisions where this section is not applicable.

Added by Laws 2008, c. 353, § 13, eff. Jan. 1, 2009.

§36-6670. Definitions.

As used in this section through Section 6676 of this title:

1. "Commissioner" means the Insurance Commissioner;

2. "Enrolled customer" means a customer who elects coverage under a portable electronics insurance policy issued to a vendor of portable electronics;

3. "Customer" means a person who purchases portable electronics or services;

4. "Location" means any physical location in the State of Oklahoma or any website, call center site, or similar location directed to residents of the State of Oklahoma;

5. "Portable electronics" means electronic devices that are portable in nature, their accessories and services related to the use of the device;

6. "Portable electronics insurance" means insurance providing coverage for the repair or replacement of portable electronics which may provide coverage for portable electronics against any one or more of the following causes of loss: loss, theft, inoperability due to mechanical failure, malfunction, damage or other similar causes of loss. "Portable electronics insurance" does not include:

- a. a service contract governed by the Service Warranty Act,
- b. a policy of insurance covering a seller's or a manufacturer's obligations under a warranty,
- c. a homeowner's, renter's, private passenger automobile, commercial multi-peril, or similar policy, or
- d. a contract excluded from the definition of a service warranty as set forth by subparagraphs a through g of paragraph 17 of Section 141.2 of Title 15 of the Oklahoma Statutes;

7. "Portable electronics transaction" means:

- a. the sale or lease of portable electronics by a vendor to a customer, or
- b. the sale of a service related to the use of portable electronics by a vendor to a customer;

8. "Supervising entity" means a business entity that is a licensed insurer or insurance producer; and

9. "Vendor" means a person in the business of engaging in portable electronics transactions directly or indirectly.

Added by Laws 2011, c. 93, § 1, eff. Nov. 1, 2011. Amended by Laws 2012, c. 147, § 1, eff. Nov. 1, 2012; Laws 2013, c. 15, § 22, emerg. eff. April 8, 2013; Laws 2016, c. 73, § 14, eff. Nov. 1, 2016.

NOTE: Laws 2012, c. 150, § 36 repealed by Laws 2013, c. 15, § 23, emerg. eff. April 8, 2013.

§36-6671. Limited lines license.

A. A vendor is required to hold a limited lines license to sell or offer coverage under a policy of portable electronics insurance.

B. A limited lines license issued pursuant to this section shall authorize any employee or authorized representative of the

vendor to sell or offer coverage under a policy of portable electronics insurance to a customer at each location at which the vendor engages in portable electronics transactions.

C. The supervising entity shall maintain a registry of vendor locations which are authorized to sell or solicit portable electronics insurance coverage in this state. Upon request by the Insurance Commissioner and with ten (10) days' notice to the supervising entity, the registry shall be open to inspection and examination by the Insurance Commissioner during regular business hours of the supervising entity.

D. Notwithstanding any other provision of law, a license issued pursuant to this section shall authorize the licensee and its employees or authorized representatives to engage in those activities that are permitted in this section.

Added by Laws 2011, c. 93, § 2, eff. Nov. 1, 2011. Amended by Laws 2012, c. 147, § 2, eff. Nov. 1, 2012.

§36-6672. Portable electronics insurance - Required brochure contents.

A. At every location where portable electronics insurance is offered to customers, brochures or other written materials must be made available to a prospective customer which:

1. Disclose that portable electronics insurance may provide a duplication of coverage already provided by a customer's homeowner's insurance policy, renter's insurance policy or other source of coverage;

2. State that the enrollment by the customer in a portable electronics insurance program is not required in order to purchase or lease portable electronics or services;

3. Summarize the material terms of the insurance coverage, including:

- a. the identity of the insurer,
- b. the identity of the supervising entity,
- c. the amount of any applicable deductible and how it is to be paid,
- d. benefits of the coverage, and
- e. key terms and conditions of coverage such as whether portable electronics may be repaired or replaced with similar make and model reconditioned or non-original manufacturer parts or equipment;

4. Summarize the process for filing a claim, including a description of how to return portable electronics and the maximum fee applicable in the event the enrolled customer fails to comply with any equipment return requirements; and

5. State that the enrolled customer may cancel enrollment for coverage under a portable electronics insurance policy at any time

and the person paying the premium shall receive a refund or credit of any applicable unearned premium refund.

B. Portable electronics insurance may be offered on a month to month or other periodic basis as a group or master commercial inland marine policy issued to a vendor of portable electronics for its enrolled customers.

C. Eligibility and underwriting standards for customers electing to enroll in coverage shall be established for each portable electronics insurance program.

Added by Laws 2011, c. 93, § 3, eff. Nov. 1, 2011. Amended by Laws 2012, c. 147, § 3, eff. Nov. 1, 2012.

§36-6673. Sale of portable electronics insurance - Licensure exemptions.

A. The employees and authorized representatives of vendors may sell or offer portable electronics insurance to customers and shall not be subject to licensure as an insurance producer pursuant to Section 2 of this act if:

1. The vendor obtains a limited lines license to authorize its employees or authorized representatives to sell or offer portable electronics insurance pursuant to Section 2 of this act;

2. The insurer issuing the portable electronics insurance either directly supervises or appoints a supervising entity to supervise the administration of the program including development of a training program for employees and authorized representatives of the vendors. The training required by this paragraph shall comply with the following:

- a. the training shall be delivered to employees and authorized representatives of a vendor who is directly engaged in the activity of selling or offering portable electronics insurance,
- b. the training may be provided in electronic form. If conducted in an electronic form, the supervising entity shall implement a supplemental education program regarding portable electronics insurance that is conducted and overseen by licensed employees of the supervising entity, and
- c. each employee and authorized representative shall receive basic instruction about the portable electronics insurance offered to customers and the disclosures required pursuant to Section 3 of this act.

No employee or authorized representative of a vendor of portable electronics shall advertise, represent or otherwise hold himself or herself out as a non limited lines licensed insurance producer.

B. The charges for portable electronics insurance coverage may be billed and collected by the vendor of portable electronics. Any

charge to the enrolled customer for coverage that is not included in the cost associated with the purchase or lease of portable electronics or related services shall be separately itemized on the enrolled customer's bill. If the coverage is included with the purchase or lease of portable electronics or related services the vendor shall clearly and conspicuously disclose to the enrolled customer that the coverage is included with the purchase of the portable electronics or related services. Vendors billing and collecting these charges shall not be required to maintain the funds in a segregated account provided that the vendor is authorized by the insurer to hold the funds in an alternative manner and to remit the amounts to the supervising entity within sixty (60) days of receipt. All funds received by a vendor from an enrolled customer for the sale of portable electronics insurance shall be considered funds held in trust by the vendor in a fiduciary capacity for the benefit of the insurer. Vendors may receive compensation for billing and collection services.

Added by Laws 2011, c. 93, § 4, eff. Nov. 1, 2011.

§36-6674. Portable electronics insurance - Violations of act.

A. If a vendor of portable electronics or its employee or authorized representative violates any provision of Sections 1 through 7 of this act, the Insurance Commissioner may:

1. After notice and hearing, impose fines not to exceed Five Hundred Dollars (\$500.00) per violation or Five Thousand Dollars (\$5,000.00) in the aggregate for such conduct; or

2. After notice and hearing, impose other penalties that the Commissioner deems necessary and reasonable to carry out the purpose of Sections 1 through 7 of this act, including:

- a. suspending the privilege of transacting portable electronics insurance pursuant to Sections 1 through 7 of this act at specific business locations where violations have occurred, and
- b. suspending or revoking the ability of individual employees or authorized representatives to act under the license.

Added by Laws 2011, c. 93, § 5, eff. Nov. 1, 2011.

§36-6675. Portable electronics insurance - Termination of policy or change in terms.

Notwithstanding any other provision of law:

1. An insurer may terminate or otherwise change the terms and conditions of a policy of portable electronics insurance only upon providing the policyholder and enrolled customers with at least thirty (30) days' notice;

2. If the insurer changes the terms and conditions of the policy, then the insurer shall provide the vendor policyholder with

a revised policy or endorsement and each enrolled customer with a revised certificate, endorsement, updated brochure, or other evidence indicating a change in the terms and conditions has occurred and a summary of material changes;

3. Notwithstanding paragraph 1 of this section, an insurer may terminate an enrolled customer's enrollment under a portable electronics insurance policy upon fifteen (15) days' notice for discovery of fraud or material misrepresentation in obtaining coverage or in the presentation of a claim thereunder;

4. Notwithstanding paragraph 2 of this section, an insurer may immediately terminate an enrolled customer's enrollment under a portable electronics insurance policy:

- a. for nonpayment of premium,
- b. if the enrolled customer ceases to have an active service with the vendor of portable electronics, or
- c. if an enrolled customer exhausts the aggregate limit of liability, if any, under the terms of the portable electronics insurance policy and the insurer sends notice of termination to the enrolled customer within thirty (30) calendar days after exhaustion of the limit. If notice is not timely sent, enrollment shall continue notwithstanding the aggregate limit of liability until the insurer sends notice of termination to the enrolled customer;

5. When a portable electronics insurance policy is terminated by a policyholder, the policyholder shall mail or deliver written notice to each enrolled customer advising the enrolled customer of the termination of the policy and the effective date of termination. The written notice shall be mailed or delivered to the enrolled customer at least thirty (30) days prior to the termination;

6. Whenever notice or correspondence with respect to coverage under a policy of portable electronics insurance is required pursuant to this section, or is otherwise required by law, it shall be in writing and sent within the notice period, if any, specified within the statute or regulation requiring the notice or correspondence. Notwithstanding any other provision of law, notices and correspondence may be sent by mail or by electronic means as set forth in this paragraph. If the notice or correspondence is mailed, it shall be sent to the vendor of portable electronics at the vendor's mailing address specified for such purpose and to its affected enrolled customers' last known mailing addresses on file with the insurer. The insurer or vendor of portable electronics, as the case may be, shall maintain proof of mailing in a form authorized or accepted by the United States Postal Service or other commercial mail delivery service. If the notice or correspondence is sent by electronic means, it shall be sent to the vendor of portable electronics at the vendor's electronic mail address

specified for such purpose and to its affected enrolled customers' last known electronic mail addresses as provided by each enrolled customer to the insurer or vendor of portable electronics, as the case may be. For purposes of this paragraph, an enrolled customer's provision of an electronic mail address to the insurer or vendor of portable electronics, as the case may be, shall be deemed consent to receive notices and correspondence by electronic means. The insurer or vendor of portable electronics, as the case may be, shall maintain proof that the notice or correspondence was sent; and

7. Notice or correspondence required by this section or otherwise required by law may be sent on behalf of an insurer or vendor, as the case may be, by the supervising entity appointed by the insurer.

Added by Laws 2011, c. 93, § 6, eff. Nov. 1, 2011. Amended by Laws 2012, c. 147, § 4, eff. Nov. 1, 2012.

§36-6676. License application requirements.

A. A sworn application for the license provided for in Section 6671 of this title shall be made to and filed with the Insurance Commissioner on forms prescribed and furnished by the Insurance Commissioner.

B. The application shall:

1. Provide the name, residence address, and other information required by the Insurance Commissioner for an employee or officer of the vendor that is designated by the applicant as the person responsible for the vendor's compliance with the requirements of Sections 6670 through 6676 of this title and update such information within thirty (30) days of a change in the same. If the vendor derives more than fifty percent (50%) of its revenue from the sale of portable electronics insurance, the information required in this subparagraph shall be provided for all officers, directors, and shareholders of record having beneficial ownership of ten percent (10%) or more of any class of securities registered under the federal securities law;

2. Appoint the Insurance Commissioner as the applicant's attorney to receive service of all legal process issued against it in any civil action or proceeding in this state and agreeing that process so served shall be valid and binding against the applicant. The appointment shall be irrevocable, shall bind the company and any successor in interest as the assets or liabilities of the applicant, and shall remain in effect as long as the applicant's license remains in force in this state; and

3. Specify the location of the applicant's home office.

C. Applications for licensure pursuant to Section 6671 of this title shall be made within ninety (90) days of the application being made available by the Insurance Commissioner.

D. Initial licenses issued pursuant to Section 6671 of this title shall be valid for a period of twenty-four (24) months.

E. Each vendor of portable electronics licensed pursuant to Sections 6670 through 6676 of this title shall pay to the Insurance Commissioner a fee as prescribed by the Insurance Commissioner but in no event shall the fee exceed One Thousand Dollars (\$1,000.00) for an initial portable electronics limited lines license and Five Hundred Dollars (\$500.00) for each renewal thereof. For a vendor that is engaged in portable electronics transactions at ten or fewer locations in the state the fee shall not exceed One Hundred Dollars (\$100.00) for an initial license and for each renewal thereof.

Added by Laws 2011, c. 93, § 7, eff. Nov. 1, 2011. Amended by Laws 2012, c. 147, § 5, eff. Nov. 1, 2012.

NOTE: Editorially renumbered from Title 36, Section 6636 to provide consistency in numbering.

§36-6680. Repealed by Laws 2018, c. 159, § 12, eff. Nov. 1, 2018.

§36-6681. Repealed by Laws 2018, c. 159, § 12, eff. Nov. 1, 2018.

§36-6682. Repealed by Laws 2018, c. 159, § 12, eff. Nov. 1, 2018.

§36-6683. Repealed by Laws 2018, c. 159, § 12, eff. Nov. 1, 2018.

§36-6684. Repealed by Laws 2018, c. 159, § 12, eff. Nov. 1, 2018.

§36-6685. Repealed by Laws 2018, c. 159, § 12, eff. Nov. 1, 2018.

§36-6701. Workers' compensation providers - Notice to policyholder.

A. Each insurance company that provides workers' compensation insurance or an equivalent insurance product in this state shall maintain or provide workplace safety services for its policyholders as a condition for approval by the Insurance Commissioner to write such insurance. Such services shall be adequate to implement workplace safety plans as required by the nature of its policyholders' operations and shall include but not be limited to surveys, recommendations, training programs, consultations, analyses of accident causes, industrial hygiene, and industrial health services.

B. Notice that workplace safety services are available to the policyholder from the insurance company must appear in no less than ten-point bold type on the front of each workers' compensation insurance or equivalent insurance policy delivered or issued for delivery in this state.

Added by Laws 1994, 2nd Ex. Sess., c. 1, § 11, emerg. eff. Nov. 4, 1994. Amended by Laws 2013, c. 254, § 27, eff. Jan. 1, 2015.

§36-6702. Repealed by Laws 2004, c. 416, § 2, emerg. eff. June 4, 2004.

§36-6710. Short title - Travel Insurance Act.

This act shall be known and may be cited as the "Travel Insurance Act".

Added by Laws 2018, c. 159, § 2, eff. Nov. 1, 2018.

§36-6711. Purpose and application of act.

A. The purpose of this act is to promote the public welfare by creating a comprehensive legal framework within which travel insurance may be sold in this state.

B. The requirements of the act shall apply to travel insurance covering any resident of this state that is sold, solicited, negotiated or offered in this state and policies and certificates that are delivered or issued for delivery in this state. It shall not apply to cancellation fee waivers and travel assistance services, except as expressly provided herein.

C. All other applicable provisions of this state's insurance laws shall continue to apply to travel insurance except that the specific provisions of the Travel Insurance Act shall supersede any general provisions of law that would otherwise be applicable to travel insurance.

Added by Laws 2018, c. 159, § 3, eff. Nov. 1, 2018. Amended by Laws 2021, c. 84, § 1, eff. Nov. 1, 2021.

§36-6712. Definitions.

As used in the Travel Insurance Act, the term:

1. "Aggregator site" means a website that provides access to information regarding insurance products from more than one insurer, including product and insurer information, for use in comparison shopping;

2. "Blanket travel insurance" means a policy of travel insurance issued to any eligible group providing coverage for specific classes of persons defined in the policy, with coverage provided to all members of the eligible group without a separate charge to individual members of the eligible group;

3. "Cancellation fee waiver" means a contractual agreement between a supplier of travel services and its customer to waive some or all of the nonrefundable cancellation fee provisions of the supplier's underlying travel contract, with or without regard to the reason for the cancellation or form of reimbursement. A cancellation fee waiver is not insurance;

4. "Commissioner" means the Oklahoma Insurance Commissioner;

5. "Eligible group" means, solely for the purposes of travel insurance, two or more persons who are engaged in a common

enterprise, or have an economic, educational or social affinity or relationship including, but not limited to, any of the following:

- a. any entity engaged in the business of providing travel or travel services including, but not limited to, tour operators, lodging providers, vacation property owners, hotels and resorts, travel clubs, travel agencies, property managers, cultural exchange programs and common carriers or the operator, owner or lessor of a means of transportation of passengers including, but not limited to, airlines, cruise lines, railroads, steamship companies and public bus carriers, wherein with regard to any particular travel or type of travel or travelers, all members or customers of the group must have a common exposure to risk attendant to such travel,
- b. any college, school or other institution of learning covering students, teachers, employees or volunteers,
- c. any employer covering any group of employees, volunteers, contractors, board of directors, dependents or guests,
- d. any sports team, camp or sponsor thereof covering participants, members, campers, employees, officials, supervisors or volunteers,
- e. any religious, charitable, recreational, educational or civic organization or branch thereof covering any group of members, participants or volunteers,
- f. any financial institution or financial institution vendor, or parent holding company, trustee or agent of or designated by one or more financial institutions or financial institution vendors, including accountholders, credit card holders, debtors, guarantors or purchasers,
- g. any incorporated or unincorporated association, including labor unions, having a common interest, constitution and bylaws and organized and maintained in good faith for purposes other than obtaining insurance for members or participants of such association covering its members,
- h. any trust or the trustees of a fund established, created or maintained for the benefit of and covering members, employees or customers, subject to the permission of the Insurance Commissioner, the use of a trust and the state's premium tax provisions in Section 6714 of this title of one or more associations meeting the above requirements of this paragraph,

- i. any entertainment production company covering any group of participants, volunteers, audience members, contestants or workers,
- j. any volunteer fire department, ambulance, rescue, police, court or any first aid, civil defense or other such volunteer group,
- k. preschools, daycare institutions for children or adults and senior citizen clubs,
- l. any automobile or truck rental or leasing company covering a group of individuals who may become renters, lessees or passengers defined by their travel status on the rented or leased vehicles. The common carrier, the operator, owner or lessor of a means of transportation or the automobile or truck rental or leasing company is the policyholder under a policy to which this paragraph applies, or
- m. any other group where the Commissioner has determined that the members are engaged in a common enterprise, or have an economic, educational or social affinity or relationship, and that issuance of the policy would not be contrary to the public interest;

6. "Fulfillment materials" means documentation sent to the purchaser of a travel protection plan confirming the purchase and providing the coverage and assistance details of the travel protection plan;

7. "Group travel insurance" means travel insurance issued to any eligible group;

8. "Limited lines travel insurance producer" means a:

- a. licensed managing general agent or third-party administrator,
- b. licensed insurance producer, including a limited lines producer, or
- c. travel administrator;

9. "Offer and disseminate" means providing general information, including a description of the coverage and price, as well as processing the application and collecting premiums;

10. "Travel administrator" means a person who directly or indirectly underwrites, collects charges, collateral or premiums from or adjusts or settles claims on residents of this state, in connection with travel insurance, except that a person shall not be considered a travel administrator if he or she is:

- a. a person working for a travel administrator whose activities are subject to the supervision and control of the travel administrator,
- b. an insurance producer selling insurance or engaged in administrative and claims-related activities within the scope of the license of the producer,

- c. a travel retailer offering and disseminating travel insurance and registered under the license of a limited lines travel insurance producer in accordance with the Travel Insurance Act,
- d. an individual adjusting or settling claims in the normal course of practice or employment of the individual as an attorney-at-law and who does not collect charges or premiums in connection with insurance coverage, or
- e. a business entity that is affiliated with a licensed insurer while acting as a travel administrator for the direct and assumed insurance business of an affiliated insurer;

11. "Travel assistance services" means noninsurance services for which the consumer is not indemnified based on a fortuitous event, and where providing the services does not result in transfer or shifting of risk that would constitute the business of insurance. Travel assistance services include, but are not limited to: security advisories; destination information; vaccination and immunization information services; travel reservation services; entertainment; activity and event planning; translation assistance; emergency messaging; international legal and medical referrals; medical case monitoring; coordination of transportation arrangements; emergency cash transfer assistance; medical prescription replacement assistance; passport and travel document replacement assistance; lost luggage assistance; concierge services; and any other service that is furnished in connection with planned travel. Travel assistance services are not insurance and not related to insurance;

12. "Travel insurance" means insurance coverage for personal risks incident to planned travel, including:

- a. interruption or cancellation of trip or event,
- b. loss of baggage or personal effects,
- c. damages to accommodations or rental vehicles,
- d. sickness, accident, disability or death occurring during travel,
- e. emergency evacuation,
- f. repatriation of remains, or
- g. any other contractual obligations to indemnify or pay a specified amount to the traveler upon determinable contingencies related to travel as approved by the Commissioner.

Travel insurance shall not include major medical plans that provide comprehensive medical protection for travelers with trips lasting longer than six (6) months including, but not limited to, those working or residing overseas as an expatriate, or any other product that requires a specific insurance producer license;

13. "Travel protection plans" means plans that provide one or more of the following: travel insurance, travel assistance services and cancellation fee waivers; and

14. "Travel retailer" means a business entity that makes, arranges or offers planned travel and may offer and disseminate travel insurance as a service to its customers on behalf of and under the direction of a limited lines travel insurance producer. Added by Laws 2018, c. 159, § 4, eff. Nov. 1, 2018. Amended by Laws 2021, c. 84, § 2, eff. Nov. 1, 2021.

§36-6713. Limited lines travel insurance producer license.

A. The Insurance Commissioner may issue a limited lines travel insurance producer license to an individual or business entity that has filed with the Commissioner an application for such license in a form and manner prescribed by the Commissioner. The limited lines travel insurance producer shall be licensed to sell, solicit or negotiate travel insurance through a licensed insurer. No person may act as a limited lines travel insurance producer or travel insurance retailer unless properly licensed or registered, respectively.

B. A travel retailer may offer and disseminate travel insurance under a limited lines travel insurance producer business entity license only if:

1. The limited lines travel insurance producer or travel retailer provides to purchasers of travel insurance:

- a. a description of the material terms or the actual material terms of the insurance coverage,
- b. a description of the process for filing a claim,
- c. a description of the review or cancellation process for the travel insurance policy, and
- d. the identity and contact information of the insurer and limited lines travel insurance producer;

2. At the time of licensure, the limited lines travel insurance producer shall establish and maintain a register on a form prescribed by the Commissioner of each travel retailer that offers travel insurance on behalf of the limited lines travel insurance. The register shall be maintained and updated by the limited lines travel insurance producer and shall include the name, address and contact information of the travel retailer and an officer or person who directs or controls the operations of the travel retailer and the federal tax identification number of the travel retailer. The limited lines travel insurance producer shall submit the register to the Insurance Department upon reasonable request. The limited lines travel insurance producer shall also certify that the registered travel retailer complies with 18 U.S.C., Section 1033. The grounds for the suspension, revocation and the penalties applicable to resident insurance producers, pursuant to Section 1435.13 of this

title, shall be applicable to the limited lines travel insurance producers and travel retailers;

3. The limited lines travel insurance producer has designated one of its employees, a designated responsible producer, who is a licensed individual producer as the person responsible for the compliance with the travel insurance laws and regulations applicable to the limited lines travel insurance producer and its registrants;

4. The designated responsible producer, president, secretary, treasurer and any other officer or person who directs or controls the limited lines travel insurance producer's insurance operations comply with the fingerprinting requirements applicable to insurance producers in the resident state of the limited lines travel insurance producer;

5. The limited lines travel insurance producer has paid all applicable insurance producer licensing fees as set forth in Section 1435.23 of this title; and

6. The limited lines travel insurance producer requires each employee and authorized representative of the travel retailer whose duties include offering and disseminating travel insurance to receive a program of instruction or training, which is subject to the discretion of the Commissioner to review and approve. The training material shall, at a minimum, contain adequate instructions on the types of insurance offered, ethical sales practices and required disclosures to prospective customers.

C. Any travel retailer offering or disseminating travel insurance shall make available to prospective purchasers brochures or other written materials that have been approved by the travel insurer. Such materials shall include information which, at a minimum:

1. Provides the identity and contact information of the insurer and the limited lines travel insurance producer;

2. Explains that the purchase of travel insurance is not required in order to purchase any other product or service from the travel retailer; and

3. Explains that an unlicensed travel retailer is permitted to provide only general information about the insurance offered by the travel retailer, including a description of the coverage and price, but is not qualified or authorized to answer technical questions about the terms and conditions of the insurance offered by the travel retailer or to evaluate the adequacy of the customer's existing insurance coverage.

D. A travel retailer employee or authorized representative who is not licensed as an insurance producer may not:

1. Evaluate or interpret the technical terms, benefits and conditions of the offered travel insurance coverage;

2. Evaluate or provide advice concerning existing insurance coverage for a prospective purchaser; or

3. Hold himself, herself or itself out as a licensed insurer, licensed producer or insurance expert.

E. Notwithstanding any other provision in law, a travel retailer whose insurance-related activities, and those of its employees and authorized representatives, are limited to offering and disseminating travel insurance on behalf of and under the direction of a limited lines travel insurance producer meeting the conditions stated in the Travel Insurance Act, is authorized to receive related compensation, upon registration by the limited lines travel insurance producer as described in paragraph 2 of subsection B of this section.

F. As the insurer designee, the limited lines travel insurance producer is responsible for the acts of the travel retailer and shall use reasonable means to ensure compliance by the travel retailer with the Travel Insurance Act.

G. Any person licensed as an insurance producer with a line of authority set forth in paragraphs 1 through 4, 6 and 7 of subsection A of Section 1435.8 of this title is authorized to sell, solicit and negotiate travel insurance. The producer is not required to be appointed by an insurer in order to sell, solicit or negotiate the travel insurance.

Added by Laws 2018, c. 159, § 5, eff. Nov. 1, 2018. Amended by Laws 2021, c. 84, § 3, eff. Nov. 1, 2021.

§36-6714. Premium tax.

A. A travel insurer shall pay premium tax, as provided in Section 624 of this title, on travel insurance premiums paid by any of the following:

1. An individual primary policyholder who is a resident of this state;

2. A primary certificate-holder who is a resident of this state who elects coverage under a group travel insurance policy; or

3. A blanket travel insurance policyholder that is a resident of this state, or has its principal place of business or the principal place of business of an affiliate or subsidiary that has purchased blanket travel insurance in this state for eligible blanket group members, subject to any apportionment rules which apply to the insurer across multiple taxing jurisdictions or that permit the insurer to allocate premium on an apportioned basis in a reasonable and equitable manner in those jurisdictions.

B. A travel insurer shall:

1. Document the state of residence or principal place of business of the policyholder or certificate-holder, as required in subsection A of this section; and

2. Report as premium only the amount allocable to travel insurance and not any amounts received for travel assistance services or cancellation fee waivers.

C. For purposes of this section:

1. "Primary certificate holder" means an individual person who elects and purchases travel insurance under a group policy; and
2. "Primary policyholder" means an individual person who elects and purchases individual travel insurance.

Added by Laws 2018, c. 159, § 6, eff. Nov. 1, 2018. Amended by Laws 2021, c. 84, § 4, eff. Nov. 1, 2021.

§36-6715. Travel protection plans.

Travel protection plans may be offered for one price for the combined features that the travel protection plan offers in this state if:

1. The travel protection plan clearly discloses to the consumer at, or prior to, the time of purchase that it includes travel insurance, travel assistance services and cancellation fee waivers as applicable, and provides information and an opportunity at, or prior to, the time of purchase for the consumer to obtain additional information regarding the features and pricing of each; and
2. The fulfillment materials:
 - a. describe and delineate the travel insurance, travel assistance services and cancellation fee waivers in the travel protection plan, and
 - b. include the applicable travel insurance disclosures and the contact information for persons providing travel assistance services and cancellation fee waiver.

Added by Laws 2018, c. 159, § 7, eff. Nov. 1, 2018.

§36-6716. Application of Unfair Trade Practices Act.

A. All persons offering travel insurance to residents of this state are subject to the Unfair Trade Practices Act pursuant to Sections 1201 through 1219 of this title, except as otherwise provided in this section. In the event of a conflict between the Travel Insurance Act and other provisions of this title regarding the sale and marketing of travel insurance and travel protection plans, the provisions of the Travel Insurance Act shall control.

B. Offering or selling a travel insurance policy that could never result in payment of any claims for any insured under the policy is an unfair trade practice under Section 1203 of this title.

C. Marketing.

1. All documents provided to consumers prior to the purchase of travel insurance including, but not limited to, sales materials, advertising materials and marketing materials, shall be consistent with the travel insurance policy including, but not limited to, forms, endorsements, policies, rate filings and certificates of insurance.

2. For travel insurance policies or certificates that contain pre-existing condition exclusions, information about the pre-existing condition exclusions shall be provided prior to the time of purchase and shall be in the fulfillment materials of the coverage.

3. The fulfillment materials and the information described in paragraph 1 of subsection B of Section 6713 of this title shall be provided to a policyholder or certificate holder as soon as practicable following the purchase of a travel protection plan. Unless the insured has either started a covered trip or filed a claim under the travel insurance coverage, a policyholder or certificate holder may cancel a policy or certificate for a full refund of the travel protection plan price from the date of purchase of the travel protection plan until at least:

- a. fifteen (15) days following the date of delivery by mail of the fulfillment materials of the travel protection plan, or
- b. ten (10) days following the date of delivery by other means of the fulfillment materials of the travel protection plan.

4. The company shall disclose in the policy documentation and fulfillment materials whether the travel insurance is primary or secondary to other applicable coverage.

5. Where travel insurance is marketed directly to a consumer through a website of the insurer or by others through an aggregator site, it shall not be an unfair trade practice or other violation of law where an accurate summary or short description of coverage is provided on the web page, so long as the consumer has access to the full provisions of the policy through electronic means.

D. A person offering, soliciting or negotiating travel insurance or travel protection plans on an individual or group basis shall not use negative option or opt-out, which would require a consumer to take an affirmative action to deselect coverage such as unchecking a box on an electronic form when the consumer purchases a trip.

E. It shall be an unfair trade practice to market blanket travel insurance coverage as free.

F. Where the destination jurisdiction of the consumer requires insurance coverage, it shall not be an unfair trade practice to require that the consumer choose between the following options as a condition of purchasing a trip or travel package:

1. Purchasing the coverage required by the destination jurisdiction through the travel retailer or limited lines travel insurance producer supplying the trip or travel package; or

2. Agreeing to obtain and provide proof of coverage that meets the requirements of the destination jurisdiction prior to departure.

Added by Laws 2018, c. 159, § 8, eff. Nov. 1, 2018. Amended by Laws 2021, c. 84, § 5, eff. Nov. 1, 2021.

§36-6717. Qualifications for travel administrators.

A. Notwithstanding any other provisions of law, no person shall act or represent itself as a travel administrator for travel insurance in this state unless that person:

1. Is a licensed property and casualty insurance producer in this state for activities permitted under that producer license;
 2. Holds a valid managing general agent license in this state;
- or
3. Holds a valid third-party administrator license in this state.

B. A travel administrator and its employees are exempt from the licensing requirements of the Insurance Adjuster Licensing Act, Sections 6201 et seq. of this title, for travel insurance it administers.

C. An insurer is responsible for the acts of a travel administrator managing travel insurance underwritten by the insurer, and is responsible for ensuring that the travel administrator maintains all books and records relevant to the insurer, to be made available by the travel administrator to the Insurance Commissioner upon request.

Added by Laws 2018, c. 159, § 9, eff. Nov. 1, 2018. Amended by Laws 2021, c. 84, § 6, eff. Nov. 1, 2021.

§36-6718. Classification and filing terms - Individual and group policies allowed.

A. Notwithstanding any other provision of the Travel Insurance Act, travel insurance shall be classified and filed for purposes of rates and forms under an inland marine line of insurance; provided, however, that travel insurance covering sickness, accident, disability or death occurring during travel, either exclusively or in conjunction with related coverages of emergency evacuation or repatriation of remains, may be filed under either an inland marine line of insurance or an accident and health line of insurance.

B. Travel insurance may be provided under an individual policy or under a group or master policy.

C. Eligibility and underwriting standards for travel insurance may be developed and provided based on travel protection plans designed for the individual or identified marketing or distribution channels, provided those standards also meet the underwriting standards for inland marine lines of insurance in this state.

Added by Laws 2018, c. 159, § 10, eff. Nov. 1, 2018. Amended by Laws 2021, c. 84, § 7, eff. Nov. 1, 2021.

§36-6719. Promulgation of rules.

The Insurance Commissioner may promulgate rules to implement the provisions of this act.

Added by Laws 2018, c. 159, § 11, eff. Nov. 1, 2018.

§36-6750. Short title.

This act shall be known and may be cited as the "Oklahoma Home Service Contract Act".

Added by Laws 2011, c. 224, § 1, eff. Nov. 1, 2011.

§36-6751. Purpose - Exemptions.

A. The purpose of the Oklahoma Home Service Contract Act is to create an independent legal framework within which home service contracts and home warranties are defined, may be sold and are regulated in this state. The Oklahoma Home Service Contract Act declares that home service contracts and home warranties, as defined in Section 6752 of this title, are not insurance and not otherwise subject to the Insurance Code. The Oklahoma Home Service Contract Act requires simple registration, financial assurance options and enforcement by the Insurance Commissioner. Proper registration under the Oklahoma Home Service Contract Act exempts applicability under the Service Warranty Act, which may regulate extended warranty, retail, automobile and agreements not defined in the Oklahoma Home Service Contract Act. Nothing in the Service Warranty Act is changed or amended by the Oklahoma Home Service Contract Act.

B. The following items are exempt from the provisions of the Oklahoma Home Service Contract Act:

1. Warranties as defined in Section 6752 of this title;
2. Maintenance agreements as defined in Section 6752 of this title; and
3. Service contracts sold or offered for sale to persons other than consumers, consumer product (extended warranty) service contracts on new retail goods if made at the time of sale and motor vehicle service contracts, all of which may be separately regulated elsewhere in the Oklahoma Statutes.

C. The types of agreements covered by the Oklahoma Home Service Contract Act are not insurance and do not have to comply with any other provision of the Insurance Code outside of the Oklahoma Home Service Contract Act.

Added by Laws 2011, c. 224, § 2, eff. Nov. 1, 2011. Amended by Laws 2012, c. 150, § 37, eff. Nov. 1, 2012; Laws 2021, c. 137, § 1, eff. Nov. 1, 2021.

§36-6752. Definitions.

As used in the Oklahoma Home Service Contract Act:

1. "Administrator" means the person who is responsible for the administration of home service contracts or the home service contracts plan, who may promote the contract under their own private label or brand as long as the provider is clearly identified on the

contract, or who is responsible for any submission required by the Oklahoma Home Service Contract Act;

2. "Commissioner" means the Insurance Commissioner;

3. "Consumer" means a natural person who buys other than for purposes of resale any tangible personal property that is distributed in commerce and that is normally used for personal, family or household purposes and not for business or research purposes;

4. "Maintenance agreement" means a contract of limited duration that provides for scheduled maintenance only and does not include repair or replacement;

5. "Person" means an individual, partnership, corporation, incorporated or unincorporated association, joint stock company, reciprocal, syndicate or any similar entity or combination of entities acting in concert;

6. "Provider" means the person who is the contractually named obligor to the home service contract holder under the terms of the service contract;

7. "Provider fee" means the consideration paid for a home service contract;

8. "Reimbursement insurance policy" means a policy of insurance issued to a provider to either provide reimbursement to the provider under the terms of the insured home service contracts issued or sold by the provider or, in the event of the provider's nonperformance, to pay on behalf of the provider all covered contractual obligations incurred by the provider under the terms of the insured home service contracts issued or sold by the provider;

9. "Home service contract" or "home warranty" means a contract or agreement for a separately stated consideration for a specific duration to perform the service, repair, replacement or maintenance of property or indemnification for service, repair, replacement or maintenance, for the operational or structural failure of any residential property due to a defect in materials, workmanship, inherent defect or normal wear and tear, with or without additional provisions for incidental payment or indemnity under limited circumstances. Home service contracts may provide for the service, repair, replacement, or maintenance of property for damage resulting from power surges or interruption and accidental damage from handling and may provide for leak or repair coverage to house roofing systems. Home service contracts and home warranties are not insurance in this state or otherwise regulated under the Insurance Code;

10. "Service contract holder" or "contract holder" means a person who is the purchaser or holder of a home service contract; and

11. "Warranty" means a warranty made solely by the manufacturer, importer or seller of property or services including

builders on new home construction, without consideration, that is not negotiated or separated from the sale of the product and is incidental to the sale of the product, that guarantees indemnity for defective parts, mechanical or electrical breakdown, labor or other remedial measures, such as repair or replacement of the property or repetition of services.

Added by Laws 2011, c. 224, § 3, eff. Nov. 1, 2011. Amended by Laws 2021, c. 137, § 2, eff. Nov. 1, 2021.

§36-6753. Home service contracts - Requirements for sale - Provider responsibilities.

A. Home service contracts shall not be issued, sold or offered for sale in this state unless the provider has:

1. Provided a receipt for, or other written evidence of, the purchase of the home service contract to the contract holder; and

2. Provided a copy of the home service contract to the service contract holder within a reasonable period of time from the date of purchase.

B. Each provider of home service contracts sold in this state shall file a registration with, and on a form prescribed by, the Insurance Commissioner consisting of their name, full corporate physical street address, telephone number, contact person and a designated person in this state for service of process. Each provider shall pay to the Commissioner a fee in the amount of One Thousand Two Hundred Dollars (\$1,200.00) upon initial registration and every three (3) years thereafter. Each provider shall pay to the Commissioner an Antifraud Assessment Fee of Two Thousand Two Hundred Fifty Dollars (\$2,250.00) upon initial registration and every three (3) years thereafter. The registration need only be updated by written notification to the Commissioner if material changes occur in the registration on file. A proper registration is de facto a license to conduct business in Oklahoma and may be suspended as provided in Section 6755 of this title. Fees received from home service contract providers shall not be subject to any premium tax, but shall be subject to an administrative fee equal to two percent (2%) of the gross fees received on the sale of all home service contracts issued in this state during the preceding calendar quarter. The fees shall be paid quarterly to the Commissioner and submitted along with a report on a form prescribed by the Commissioner. However, service contract providers may elect to pay an annual administrative fee of Three Thousand Dollars (\$3,000.00) in lieu of the two-percent administrative fee, if the provider maintains an insurance policy or policies as provided in paragraph 3 of subsection C of this section.

C. In order to assure the faithful performance of a provider's obligations to its contract holders, each provider shall be

responsible for complying with the requirements of paragraph 1, 2 or 3 of this subsection:

1. a. maintain a funded reserve account for its obligations under its contracts issued and outstanding in this state. The reserves shall not be less than forty percent (40%) of gross consideration received, less claims paid, on the sale of the service contract for all in-force contracts. The reserve account shall be subject to examination and review by the Commissioner, and
- b. place in trust with the Commissioner a financial security deposit, having a value of not less than five percent (5%) of the gross consideration received, less claims paid, on the sale of the service contract for all service contracts issued and in force, but not less than Twenty-five Thousand Dollars (\$25,000.00), consisting of one of the following:
 - (1) a surety bond issued by an authorized surety,
 - (2) securities of the type eligible for deposit by authorized insurers in this state,
 - (3) a letter of credit issued by a qualified financial institution, or
 - (4) another form of security prescribed by rule promulgated by the Commissioner;
2. a. maintain, or together with its parent company maintain, a net worth or stockholders' equity of Twenty-five Million Dollars (\$25,000,000.00), excluding goodwill, intangible assets, customer lists and affiliated receivables, and
- b. upon request, provide the Commissioner with a copy of the provider's or the provider's parent company's most recent Form 10-K or Form 20-F filed with the Securities and Exchange Commission (SEC) within the last calendar year, or if the company does not file with the SEC, a copy of the company's financial statements, which shows a net worth of the provider or its parent company of at least Twenty-five Million Dollars (\$25,000,000.00) based upon Generally Accepted Accounting Principles (GAAP) accounting standards. If the provider's parent company's Form 10-K, Form 20-F, or financial statements are filed to meet the provider's financial stability requirement, then the parent company shall agree to guarantee the obligations of the provider relating to service contracts sold by the provider in this state; or
3. Purchase one or more insurance policies which collectively cover one hundred percent (100%) of its claim exposure. The

insurance shall be obtained from one or more insurers that are 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 D of this section. For the purposes of this paragraph, the insurance policy or policies shall contain the following provisions:

- a. in the event that the provider is unable to fulfill its obligation under contracts issued in this state for any reason including insolvency, bankruptcy, or dissolution, the insurer shall pay losses and unearned premiums under such plans directly to the person making the claim under the contract,
- b. the insurer issuing the insurance policy shall assume full responsibility for the administration of claims in the event of the inability of the provider to do so, and
- c. the policy shall not be canceled or not renewed by either the insurer or the provider unless sixty (60) days' written notice thereof has been given to the Commissioner by the insurer before the date of such cancellation or nonrenewal.

D. Each insurer providing an insurance policy used to satisfy the financial responsibility requirements of paragraph 3 of subsection C of this section shall 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 National Association of Insurance Commissioners (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),
 - 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.

E. Except for the registration requirements in subsection B of this section, providers, administrators and other persons marketing, selling or offering to sell home service contracts are exempt from any licensing requirements of this state and shall not be subject to other registration information or security requirements. Home service contract providers as defined in Section 6752 of this title and properly registered under this law are exempt from any treatment pursuant to the Service Warranty Act. Home service contract providers applying for registration under the Oklahoma Home Service Contract Act that have not been registered in the preceding twelve (12) months under the Oklahoma Home Service Contract Act may be subject to a thirty-day prior review before their registration is deemed complete. Said applications shall be deemed complete after thirty (30) days unless the Commissioner takes action in that period under Section 6755 of this title, for cause shown, to suspend their registration.

F. The marketing, sale, offering for sale, issuance, making, proposing to make and administration of home service contracts by providers and related service contract sellers, administrators, and other persons including but not limited to real estate licensees, shall be exempt from all other provisions of the Insurance Code. Added by Laws 2011, c. 224, § 4, eff. Nov. 1, 2011. Amended by Laws 2012, c. 150, § 38, eff. Nov. 1, 2012; Laws 2021, c. 478, § 35, emerg. eff. May 12, 2021; Laws 2022, c. 248, § 4, eff. Nov. 1, 2022.

§36-6754. Service contracts - Content.

A. Service contracts marketed, sold, offered for sale, issued, made, proposed to be made, or administered in this state shall be written, printed, or typed in clear, understandable language that is easy to read, and shall disclose the requirements set forth in this section, as applicable. Each service contract provider shall, upon initial registration and at renewal of its registration, file a copy of each of its current contracts issued in this state for informational purposes. The provider shall update a filing any time a change is made to the service contract that materially affects the rights or obligations of a contract holder or upon written request by the Department.

B. Service contracts insured under an insurance policy pursuant to paragraph 3 of subsection C of Section 6753 of this title shall contain a statement in substantially the following form: "Obligations of the provider under this service contract are insured under a service contract reimbursement insurance policy." The service contract shall also state the name and address of the insurer.

C. Service contracts not insured under an insurance policy pursuant to paragraph 3 of subsection C of Section 6753 of this title shall contain a statement in substantially the following form: "Obligations of the provider under this service contract are backed by the full faith and credit of the provider."

D. Service contracts shall state the name and address of the provider, and shall identify any administrator if different from the provider, the service contract seller, and the service contract holder to the extent that the name of the service contract holder has been furnished by the service contract holder. The identities of such parties are not required to be preprinted on the service contract and may be added to the service contract at the time of sale.

E. Service contracts shall state the total purchase price and the terms under which service contract is sold. The purchase price is not required to be preprinted on the service contract and may be negotiated at the time of sale with the service contract holder.

F. Service contracts shall state the existence of any trade service fee, if applicable.

G. Service contracts shall specify the merchandise and services to be provided and any limitations, exceptions, or exclusions.

H. Service contracts shall state any restrictions governing the transferability of the service contract, if applicable.

I. Service contracts shall state the terms, restrictions or conditions governing cancellation of the service contract.

J. Service contracts shall set forth all of the obligations and duties of the service contract holder, such as the duty to protect against any further damage and any requirement to follow the owner's manual.

K. Service contracts shall state whether or not the service contract provides for or excludes consequential damages or preexisting conditions, if applicable. Service contracts may, but are not required to, cover damage resulting from rust, corrosion or damage caused by a noncovered part or system.

L. If prior approval of repair work is required, a service contract shall state the procedure for obtaining prior approval and for making a claim, including a toll-free telephone number for claim service and a procedure for obtaining emergency repairs performed outside of normal business hours.

Added by Laws 2011, c. 224, § 5, eff. Nov. 1, 2011. Amended by Laws 2019, c. 294, § 12, eff. Nov. 1, 2019.

§36-6755. Examination and enforcement of act.

A. After initial registration, and upon complaint or proper cause shown, providers, administrators, insurers or other persons shall be subject to periodic examination by the Insurance

Commissioner, in the same manner and subject to the same terms and conditions that apply to insurers.

B. The Commissioner may take action which is necessary or appropriate to enforce the provisions of the Oklahoma Home Service Contract Act and the orders of the Commissioner and to protect service contract holders in this state.

1. If a provider has violated the Oklahoma Home Service Contract Act or the Commissioner's rules or orders, the Commissioner may issue an order directed to that provider to cease and desist from committing violations of the Oklahoma Home Service Contract Act or the Commissioner's rules or orders, may issue an order prohibiting a service contract provider from selling or offering for sale service contracts in violation of the Oklahoma Home Service Contract Act, suspend that provider's registration or may issue an order imposing a civil penalty on that provider, or any combination of the following, as applicable:

- a. a person aggrieved by an order issued under this paragraph may request a hearing before the Commissioner. The hearing request shall be filed with the Commissioner within twenty (20) days of the date the Commissioner's order is effective,
- b. if a hearing is requested, an order issued by the Commissioner under this section shall be suspended from the original effective date of the order until completion of the hearing and final decision of the Commissioner, and
- c. at the hearing, the burden shall be on the Commissioner to show why the order issued pursuant to this paragraph is justified. The hearing requested under this section shall be held in accordance with the Administrative Procedures Act and the laws and rules of the Insurance Department.

2. The Commissioner may bring an action in any court of competent jurisdiction for an injunction or other appropriate relief to enjoin threatened or existing violations of the Oklahoma Home Service Contract Act or of the Commissioner's orders or rules. An action filed under this paragraph may also seek restitution on behalf of persons aggrieved by a violation of the Oklahoma Home Service Contract Act or orders or rules of the Commissioner.

3. A person who is found to have violated the Oklahoma Home Service Contract Act or orders or rules of the Commissioner may be assessed a civil penalty in an amount determined by the Commissioner of not more than Five Hundred Dollars (\$500.00) per violation and no more than Ten Thousand Dollars (\$10,000.00) in the aggregate for all violations of a similar nature. For purposes of this section, violations shall be of a similar nature if the violation consists of the same or similar course of conduct, action, or practice,

irrespective of the number of times the act, conduct, or practice which is determined to be a violation of the Oklahoma Home Service Contract Act occurred. This act is administrative only and nothing in this act shall be construed to create a private cause of action hereunder.

Added by Laws 2011, c. 224, § 6, eff. Nov. 1, 2011.

§36-6801. Short title.

This act shall be known and may be cited as the "Oklahoma Telemedicine Act".

Added by Laws 1997, c. 209, § 1, eff. July 1, 1997.

§36-6802. See the following versions:

OS 36-6802v1 (SB 673, Laws 2021, c. 293, § 1).

OS 36-6802v2 (HB 2120, Laws 2021, c. 549, § 1).

§36-6802v1. Telemedicine defined.

As used in the Oklahoma Telemedicine Act, "telemedicine" means technology-enabled health and care management and delivery systems that extend capacity and access, which includes:

- a. synchronous mechanisms, which may include live audiovisual interaction between a patient and a health care professional or real-time provider to provider consultation through live interactive audiovisual means,
- b. asynchronous mechanisms, which include store and forward transfers, online exchange of health information between a patient and a health care professional and online exchange of health information between health care professionals, but shall not include the use of automated text messages or automated mobile applications that serve as the sole interaction between a patient and a health care professional,
- c. remote patient monitoring, and
- d. other electronic means that support clinical health care, professional consultation, patient and professional health-related education, public health and health administration.

Added by Laws 1997, c. 209, § 2, eff. July 1, 1997. Amended by Laws 2009, c. 148, § 6, eff. Nov. 1, 2009; Laws 2021, c. 293, § 1, eff. Nov. 1, 2021.

§36-6802v2. Definitions.

As used in the Oklahoma Telemedicine Act:

1. "Distant site" means a site at which a health care professional licensed to practice in this state is located while providing health care services by means of telemedicine;

2. a. "Health benefits plan" means any plan or arrangement that:

- (1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident or illness, and
- (2) is offered by any insurance company, group hospital service corporation or health maintenance organization that delivers or issues for delivery an individual, group, blanket or franchise insurance policy or insurance agreement, a group hospital service contract or an evidence of coverage, or, to the extent permitted by the Employee Retirement Income Security Act of 1974, 29 U.S.C., Section 1001 et seq., by a multiple employer welfare arrangement as defined in Section 3 of the Employee Retirement Income Security Act of 1974, or any other analogous benefit arrangement, whether the payment is fixed or by indemnity,

b. Health benefits plan shall not include:

- (1) a plan that provides coverage:
 - (a) only for a specified disease or diseases or under an individual limited benefit policy,
 - (b) only for accidental death or dismemberment,
 - (c) only for dental or vision care,
 - (d) for a hospital confinement indemnity policy,
 - (e) for disability income insurance or a combination of accident-only and disability income insurance, or
 - (f) as a supplement to liability insurance,
- (2) a Medicare supplemental policy as defined by Section 1882(g)(1) of the Social Security Act (42 U.S.C., Section 1395ss),
- (3) workers' compensation insurance coverage,
- (4) medical payment insurance issued as part of a motor vehicle insurance policy,
- (5) a long-term care policy including a nursing home fixed indemnity policy, unless a determination is made that the policy provides benefit coverage so comprehensive that the policy meets the definition of a health benefits plan,
- (6) short-term health insurance issued on a nonrenewable basis with a duration of six (6) months or less, or

(7) a plan offered by the Employees Group Insurance Division of the Office of Management and Enterprise Services;

3. "Health care professional" means a physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law;

4. "Insurer" means any entity providing an accident and health insurance policy in this state including, but not limited to, a licensed insurance company, a not-for-profit hospital service and medical indemnity corporation, a fraternal benefit society, a multiple employer welfare arrangement or any other entity subject to regulation by the Insurance Commissioner;

5. "Originating site" means a site at which a patient is located at the time health care services are provided to him or her by means of telemedicine, which may include, but shall not be restricted to, a patient's home, workplace or school;

6. "Remote patient monitoring services" means the delivery of home health services using telecommunications technology to enhance the delivery of home health care including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose and other condition-specific data, medication adherence monitoring and interactive video conferencing with or without digital image upload;

7. "Store and forward transfer" means the transmission of a patient's medical information either to or from an originating site or to or from the health care professional at the distant site, but does not require the patient being present nor must it be in real time; and

8. "Telemedicine" or "telehealth" means technology-enabled health and care management and delivery systems that extend capacity and access, which includes:

- a. synchronous mechanisms, which may include live audiovisual interaction between a patient and a health care professional or real-time provider-to-provider consultation through live interactive audiovisual means,
- b. asynchronous mechanisms, which include store and forward transfers, online exchange of health information between a patient and a health care professional and online exchange of health information between health care professionals, but shall not include the use of automated text messages or automated mobile applications that serve as the sole interaction between a patient and a health care professional,
- c. remote patient monitoring, and

- d. other electronic means that support clinical health care, professional consultation, patient and professional health-related education, public health and health administration.

Added by Laws 1997, c. 209, § 2, eff. July 1, 1997. Amended by Laws 2009, c. 148, § 6, eff. Nov. 1, 2009; Laws 2021, c. 420, § 1, eff. Nov. 1, 2021; Laws 2021, c. 549, § 1, eff. Jan. 1, 2022.

§36-6803. Coverage of services - Requirements for insurers.

A. For services that a health care professional determines to be appropriately provided by means of telemedicine, health care service plans, disability insurer programs, workers' compensation programs, or state Medicaid managed care program contracts issued, amended, or renewed on or after January 1, 1998, shall not require person-to-person contact between a health care professional and a patient.

B. Subsection A of this section shall apply to health care service plan contracts with the state Medicaid managed care program only to the extent that both of the following apply:

1. Telemedicine services are covered by, and reimbursed under, the fee-for-service provisions of the state Medicaid managed care program; and

2. State Medicaid managed care program contracts with health care service plans are amended to add coverage of telemedicine services and make any appropriate capitation rate adjustments.

C. Any health benefit plan that is offered, issued or renewed in this state by an insurer on or after the effective date of this act shall provide coverage of health care services provided through telemedicine, as provided in this section.

D. An insurer shall not exclude a service for coverage solely because the service is provided through telemedicine and is not provided through in-person consultation or contact between a health care professional and a patient when such services are appropriately provided through telemedicine. An insurer may limit coverage of services provided by telehealth consistent with coding and clinical standards recognized by the American Medical Association or the Centers for Medicare and Medicaid Services as covered if delivered by telehealth or telemedicine, except as agreed to by the insurer and provider.

E. An insurer shall reimburse the treating health care professional or the consulting health care professional for the diagnosis, consultation or treatment of the patient delivered through telemedicine services on the same basis and at least at the rate of reimbursement that the insurer is responsible for coverage for the provision of the same, or substantially similar, services through in-person consultation or contact.

F. An insurer shall not apply any deductible to telemedicine services that accumulates separately from the deductible that applies in the aggregate to all items and services covered under the health benefit plan.

G. Any copayment or coinsurance applied to telemedicine benefits by an insurer shall not exceed the copayment or coinsurance applied to such benefits when provided through in-person consultation or contact.

H. An insurer shall not impose any annual or lifetime durational limits or annual or lifetime dollar maximums for benefits or services provided through telemedicine that are not equally imposed upon all terms and services covered under the health benefit plan.

I. An insurer shall not impose any type of utilization review on benefits provided through telemedicine unless such type of utilization review is imposed when such benefits are provided through in-person consultation or contact. Any type of utilization review that is imposed on benefits provided through telemedicine shall not occur with greater frequency or more stringent application than such form of utilization review is imposed on such benefits provided through in-person consultation or contact.

J. An insurer shall not restrict coverage of telemedicine benefits or services to benefits or services provided by a particular vendor, or other third party, or benefits or services provided through a particular electronic communications technology platform; provided, that nothing shall require an insurer to cover any electronic communications technology platform that does not comply with applicable state and federal privacy laws.

K. An insurer shall not place any restrictions on prescribing medications through telemedicine that are more restrictive than what is required under applicable state and federal law.

L. No later than January 1, 2023, the State Department of Health shall request a report from the Statewide Health Information Exchange that will provide the following data:

1. The number of providers using telehealth, including the location, frequency and specific services for which telehealth is utilized; and

2. The overall cost and cost savings associated with the utilization of telehealth services.

Added by Laws 1997, c. 209, § 3, eff. July 1, 1997. Amended by Laws 2021, c. 420, § 2, eff. Jan. 1, 2022.

§36-6804. Repealed by Laws 2016, c. 162, § 1, eff. Nov. 1, 2016.

§36-6810. Definitions.

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. The Medical Professional Liability Insurance Closed Claim Reports Act shall apply to all medical professional liability claims in this state, regardless of whether or how the claims are covered by medical professional liability insurance.

C. As used in the Medical Professional Liability Insurance Closed Claim Reports Act:

1. "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.

Added by Laws 2003, c.390, § 11, eff. July 1, 2003. Amended by Laws 2009, c. 176, § 54, eff. Nov. 1, 2009; Laws 2010, c. 222, § 51, eff. Nov. 1, 2010.

§36-6811. Time for filing closed claim report.

A. The Insurance Commissioner may require that an insuring entity or self-insured entity shall file a closed claim report. These reports shall be filed within thirty (30) days after the Commissioner's request and shall include data for all claims closed in the preceding calendar year and other information required by the Commissioner.

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. 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.

D. If a claim is not covered by an insuring entity or self-insurer, the facility or provider named in the claim shall 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.

E. 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 shall 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 shall 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 shall 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 shall report all data required by the Medical Professional Liability Insurance Closed Claim Reports Act on behalf of the captive insurer.

Added by Laws 2003, c.390 , § 12, eff. July 1, 2003. Amended by Laws 2009, c. 176, § 55, eff. Nov. 1, 2009; Laws 2010, c. 222, § 52, eff. Nov. 1, 2010; Laws 2011, c. 278, § 52, eff. Nov. 1, 2011; Laws 2015, c. 298, § 28, eff. Nov. 1, 2015.

§36-6812. Repealed by Laws 2009, c. 176, § 61, eff. Nov. 1, 2009.

§36-6812.1. Required information, format, and coding protocol in reports.

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. Added by Laws 2009, c. 176, § 56, eff. Nov. 1, 2009.

§36-6813. Compilation of data - Report.

The Department shall compile the data included in individual closed claim reports filed pursuant to this act into a composite form and shall prepare annually a written report of the composite data. The Department shall make the composite data report available to the public.

Added by Laws 2003, c.390, § 14, eff. July 1, 2003.

§36-6814. Electronic database.

The Commissioner shall:

1. Establish an electronic database composed of composite data reports required pursuant to Section 14 of this act;
 2. Provide the public with access to that data;
 3. Establish a system to provide access to that data by electronic data transmittal processes; and
 4. Set and charge a fee for electronic access to the database in an amount reasonable and necessary to cover the costs of access.
- Added by Laws 2003, c. 390, § 15, eff. July 1, 2003.

§36-6815. Submission of composite data reports Governor and Legislature.

A. The Department shall submit copies of the composite data report required pursuant to Section 14 of this act to the Governor, the President Pro Tempore of the Senate and the Speaker of the House of Representatives.

B. The Department, on request of the Governor, the President Pro Tempore of the Senate, or the Speaker of the House of Representatives, shall provide to the Governor and the Legislature additional composite data reports. Composite data reports prepared under this subsection shall be available to the public.

Added by Laws 2003, c. 390, § 16, eff. July 1, 2003.

§36-6816. Confidentiality.

A. Information included in an individual closed claim report submitted by an insurer under Sections 12 and 13 of this act is confidential and shall not be made available by the Department to the public and shall not be subject to the Oklahoma Open Records Act.

B. Information included in an individual closed claim report may be examined only by the Commissioner and Department employees.

Added by Laws 2003, c. 390, § 17, eff. July 1, 2003.

§36-6817. Designated statistical agent - Definition.

STATISTICAL DATA COLLECTION

As used in Sections 19 and 20 of this act, "designated statistical agent" means an organization designated or contracted with by the Commissioner pursuant to Section 19 of this act.

Added by Laws 2003, c. 390, § 18, eff. July 1, 2003.

§36-6818. Designation of or contract with organization to serve as statistical agent.

The Insurance Commissioner may designate or contract with a qualified organization to serve as the statistical agent for the Commissioner to analyze the information provided pursuant to Sections 12 and 13 of this act.

Added by Laws 2003, c. 390, § 19, eff. July 1, 2003.

§36-6819. Qualifications for statistical agent.

To qualify as a statistical agent, an organization must demonstrate at least five (5) years of experience in data collection, data maintenance, data quality control, accounting and other related areas.

Added by Laws 2003, c. 390, § 20, eff. July 1, 2003.

§36-6820. Provision of premium and loss cost data.

An insurer shall provide all premium and loss cost data to the Insurance Commissioner as the Commissioner requires.

Added by Laws 2003, c. 390, § 21, eff. July 1, 2003.

§36-6821. Repealed by Laws 2013, c. 269, § 26, eff. Nov. 1, 2013.

§36-6830. Insurance compliance audits - Confidentiality.

A. Except as provided in Sections 2 and 3 of this act, an insurance compliance self-evaluative audit is privileged information and is not discoverable, or admissible as evidence in any legal action in any civil, criminal, or administrative proceeding. The privilege created herein is a matter of substantive law of this state and is not merely a procedural matter governing civil or criminal procedures in the courts of this state.

B. If any company, person, or entity performs or directs the performance of an insurance compliance audit, an officer, employee or agent involved with the insurance audit, or any consultant who is hired for the purpose of performing the insurance compliance audit, may not be examined in any civil, criminal, or administrative proceeding as to the insurance compliance audit or any insurance compliance self-evaluative audit document, as defined in this section. This section does not apply if the privilege set forth in subsection A of this section is determined under Section 2 or 3 of this act not to apply.

C. A company may voluntarily submit, in connection with examinations conducted under this act, an insurance compliance self-evaluative audit document to the Insurance Commissioner, or designee, as a confidential document without waiving the privilege set forth in this section to which the company would otherwise be entitled; provided, however, that the provisions of the Oklahoma Insurance Code permitting the Commissioner to make confidential documents public and grant access to documents to the National Association of Insurance Commissioners shall not apply to the insurance compliance self-evaluative audit document. Any such report furnished to the Insurance Commissioner shall not be provided to any other persons or entities and shall be accorded the same confidentiality and other protections as provided above for voluntarily submitted documents.

D. A company's insurance compliance self-evaluative audit document submitted to the Commissioner shall remain subject to all applicable statutory or common law privileges including, but not limited to, the work product doctrine, attorney-client privilege, or the subsequent remedial measures exclusion.

E. Any compliance self-evaluative audit document so submitted and in the possession of the Commissioner shall remain the property of the company and shall not be subject to any disclosure or production under the Oklahoma Open Records Act.

F. Disclosure of an insurance compliance self-evaluative audit document to a governmental agency, whether voluntary or pursuant to compulsion of law, shall not constitute a waiver of the privilege set forth in subsection A of this section with respect to any other persons or any other governmental agencies.

Added by Laws 2012, c. 257, § 1, eff. Nov. 1, 2012.

§36-6831. Applicability of confidentiality privilege - Disclosure.

A. The privilege set forth in Section 1 of this act does not apply:

1. To the extent that it is expressly waived by the company that prepared or caused to be prepared the insurance compliance self-evaluative audit document;

2. If the company that prepared or caused to be prepared the insurance compliance self-evaluative audit document provides the audit or any audit documents to any witness for the purpose of testimonial use in the matter in which the privilege is being asserted; or

3. If the insurance compliance self-evaluative audit document shows evidence of noncompliance with applicable state or federal laws, rules, regulations or orders and appropriate efforts to achieve compliance with such laws, rules, regulations or orders were not initiated within a reasonable time and pursued with reasonable diligence upon discovery of noncompliance.

B. In a civil or administrative proceeding, a court of record may, after an in camera review, require disclosure of material for which the privilege set forth in Section 1 of this act is asserted, if the court determines one of the following:

1. The privilege is intentionally asserted in bad faith or for a fraudulent or any other similar improper purpose; or

2. The material is not subject to the privilege.

If the court requires disclosure because of paragraph 1 of this subsection, the court may impose sanctions as for any other violation of the rules of discovery.

C. In a criminal proceeding, a court of record may, after an in camera review, require disclosure of material for which the privilege described in Section 1 of this act is asserted, if the court determines one of the following:

1. The privilege is asserted in bad faith or for a fraudulent or any other similar improper purpose;
2. The material is not subject to the privilege; or
3. The material contains evidence relevant to commission of a criminal offense, and all three of the following factors are present:
 - a. the Insurance Commissioner, district attorney, or Attorney General has a compelling need for the information,
 - b. the information is not otherwise available, and
 - c. the Insurance Commissioner, district attorney, or Attorney General is unable to obtain the substantial equivalent of the information by any other means without incurring unreasonable cost and delay.

Added by Laws 2012, c. 257, § 2, eff. Nov. 1, 2012.

§36-6832. Petition for in camera hearing - Contents.

A. Within thirty (30) days after the Insurance Commissioner, district attorney, Attorney General, or opposing party in a civil, criminal or administrative proceeding, serves on an insurer a written request by certified mail for disclosure of an insurance compliance self-evaluative audit document under this act, the company that prepared or caused the document to be prepared may file with the appropriate court a petition requesting an in camera hearing on whether the insurance compliance self-evaluative audit document or portions of the document are privileged or subject to disclosure. Failure by the company to file a petition waives the privilege for this request only.

B. A company asserting the insurance compliance self-evaluative privilege in response to a request for disclosure under this act shall include in its request for an in camera hearing all of the information set forth in subsection E of this section.

C. Upon the filing of a petition under this section, the court shall issue an order scheduling, within forty-five (45) days after the filing of the petition, an in camera hearing to determine whether the insurance compliance self-evaluative audit document or portions of the document are privileged under this section or subject to disclosure.

D. The court, after an in camera review, may require disclosure of material for which the privilege in Section 1 of this act is asserted if the court determines, based upon its in camera review, that any one of the conditions set forth in subsection B of Section 2 of this act is applicable as to a civil or administrative proceeding or that any one of the conditions set forth in subsection C of Section 2 of this act is applicable as to a criminal proceeding. Upon making such a determination, the court may only compel the disclosure of those portions of an insurance compliance

self-evaluative audit document relevant to issues in dispute in the underlying proceeding. Any compelled disclosure will not be considered to be a public document or be deemed to be a waiver of the privilege for any other civil, criminal, or administrative proceeding. A party unsuccessfully opposing disclosure may apply to the court for an appropriate order protecting the document from further disclosure.

E. A company asserting the insurance compliance self-evaluative privilege in response to a request for disclosure under this act shall provide to the Insurance Commissioner, district attorney, Attorney General, or opposing party in a civil, criminal or administrative proceeding, as the case may be, at the time of filing any objection to the disclosure, all of the following information:

1. The date of the insurance compliance self-evaluative audit document;
2. The identity of the entity conducting the audit;
3. The general nature of the activities covered by the insurance compliance self-evaluative audit; and
4. An identification of the portions of the insurance compliance self-evaluative audit document for which the privilege is being asserted.

Added by Laws 2012, c. 257, § 3, eff. Nov. 1, 2012.

§36-6833. Burden of proof.

A. A company asserting the insurance compliance self-evaluative privilege set forth in Section 1 of this act has the burden of demonstrating the applicability of the privilege. Once a company has established the applicability of the privilege, the party seeking disclosure under this act has the burden of proving that the privilege is asserted in bad faith or for a fraudulent or any other similar improper purpose. The Insurance Commissioner, district attorney, or Attorney General seeking disclosure under this act has the burden of proving the elements set forth in subsection B or C of Section 2 of this act.

B. The parties may at any time stipulate in proceedings under Section 2 or 3 of this act to entry of an order directing that specific information contained in an insurance compliance self-evaluative audit document is or is not subject to the privilege provided under Section 1 of this act. Any such stipulation may be limited to the instant proceeding and, absent specific language to the contrary, shall not be applicable to any other proceeding.

Added by Laws 2012, c. 257, § 4, eff. Nov. 1, 2012.

§36-6834. Non-privileged information.

The privilege set forth in Section 1 of this act shall not extend to any of the following:

1. Documents, communications, data, reports, or other information expressly required to be collected, developed, maintained, or reported to a regulatory agency pursuant to this act, or other federal or state law;

2. Information obtained by observation, monitoring or examination by any regulatory agency;

3. Information contained from a source independent of the insurance compliance audit; or

4. Documents and other material created or maintained in the ordinary course of the insurer's business, specifically including communications between the insurer and insureds, individual claim files and any other similar documents which are currently discoverable under existing law.

Added by Laws 2012, c. 257, § 5, eff. Nov. 1, 2012.

§36-6835. Definitions.

As used in this act:

1. "Insurance compliance audit" means a voluntary internal evaluation, review, assessment, audit, or investigation for the purpose of identifying or preventing noncompliance with, or promoting compliance with, laws, regulations, orders, or industry or professional standards, which is conducted by or on behalf of a company licensed or regulated under the Oklahoma Insurance Code, or which involves an activity regulated under this Code. Once initiated, an audit shall be completed within a reasonable period of time. Nothing in this section shall be construed to authorize uninterrupted or continuous auditing; and

2. "Insurance compliance self-evaluative audit document" means documents prepared as a result of or in connection with an insurance compliance audit. An insurance compliance self-evaluative audit document may include, but is not limited to, as applicable, field notes and records of observations, findings, opinions, suggestions, conclusions, drafts, memoranda, drawings, photographs, exhibits, computer-generated or electronically recorded information, phone records, maps, charts, graphs, and surveys; provided, this supporting information is collected or developed for the primary purpose and in the course of an insurance compliance audit. An insurance compliance self-evaluative audit document also includes, but is not limited to, any of the following:

- a. an insurance compliance audit report prepared by an auditor, who may be an employee of the company or an independent contractor, which may include the scope of the audit, the information gained in the audit, and conclusions and recommendations, with exhibits and appendices,

- b. memoranda and documents analyzing portions or all of the insurance compliance audit report and discussing potential implementation issues,
- c. an implementation plan that addresses correcting past noncompliance, improving current compliance, and preventing future noncompliance, or
- d. analytic data generated in the course of conducting the insurance compliance audit.

Documents, communications, data, reports or other information which are created as a result of a claim involving personal injury, property damage or workers' compensation made against an insurance policy are not insurance compliance self-evaluative audit documents and are admissible as evidence in civil, criminal or administrative proceedings as otherwise provided by applicable rules of evidence or civil procedure, subject to any applicable statutory or common-law privilege.

Added by Laws 2012, c. 257, § 6, eff. Nov. 1, 2012.

§36-6836. Privilege effective date.

The insurance compliance self-evaluative privilege created by this act shall apply to all audits performed or commissioned after the effective date of this act, whether or not the litigation or administrative proceedings were pending on the effective date of this act.

Added by Laws 2012, c. 257, § 7, eff. Nov. 1, 2012.

§36-6837. Effect upon statutory or common law privileges.

Nothing in this act nor the release of any self-evaluative audit document hereunder shall limit, waive, or abrogate the scope or nature of any statutory or common law privilege including, but not limited to, the work product doctrine, the attorney-client privilege, or the subsequent remedial measures exclusion.

Added by Laws 2012, c. 257, § 8, eff. Nov. 1, 2012.

§36-6850.1. Notification of deletions in prescription coverage.

Any health benefit plan that provides prescription drug coverage or contracts with a third party for prescription drug services shall notify an enrollee presently taking a prescription drug of any deletions, other than generic substitutions, in the health benefit plan's prescription drug formulary. Such notification shall be made in writing, or electronically upon request of the enrollee, at least sixty (60) days prior.

This section does not apply to coverage for a drug that is determined by a therapeutics committee of the health benefit plan to be subject to new safety warnings or a safety recall by the Federal Drug Administration.

As used in this section, "health benefit plan" means any plan or arrangement as defined in subsection C of Section 6060.4 of Title 36 of the Oklahoma Statutes.

Added by Laws 2013, c. 247, § 1, eff. Nov. 1, 2013.

§36-6901. Short title.

This act shall be known and may be cited as the "Health Maintenance Organization Act of 2003".

Added by Laws 2003, c. 197, § 1, eff. Nov. 1, 2003.

§36-6902. Definitions.

As used in the Health Maintenance Organization Act of 2003:

1. "Basic health care services" means the following medically necessary services:

- a. preventive care,
- b. emergency care,
- c. inpatient and outpatient hospital and physician care,
- d. diagnostic laboratory and diagnostic and therapeutic radiological services,
- e. allopathic, osteopathic, chiropractic, podiatric, optometric, psychological, outpatient diagnostic treatment,
- f. short-term rehabilitation and physical therapy,
- g. emergency, short-term outpatient mental health, substance abuse diagnostic and medical treatment,
- h. home health, and
- i. preventive health services;

provided, however, such term does not include dental services or long-term rehabilitation treatment;

2. "Capitated basis" means fixed per member per month payment or percentage of premium payment wherein the provider assumes the full risk for the cost of contracted services without regard to the type, value or frequency of services provided. For purposes of this definition, "capitated basis" includes the cost associated with operating staff model facilities;

3. "Carrier" means a health maintenance organization, an insurer, a nonprofit hospital and medical service corporation, or other entity responsible for the payment of benefits or provision of services under a group contract;

4. "Copayment" means an amount an enrollee must pay in order to receive a specific service which is not fully prepaid;

5. "Deductible" means the amount an enrollee is responsible to pay out-of-pocket before a health maintenance organization begins to pay the costs associated with treatment;

6. "Enrollee" means an individual who is covered by a health maintenance organization;

7. "Evidence of coverage" means a statement of the essential features and services of the health maintenance organization coverage which is given to the subscriber by the health maintenance organization or by the group contract holder;

8. "Extension of benefits" means the continuation of coverage under a particular benefit provided under a contract following termination for an enrollee who is totally disabled on the date of termination;

9. "Grievance" means a written complaint, submitted in accordance with a health maintenance organization's formal grievance procedure, by or on behalf of an enrollee regarding any aspect of the health maintenance organization relative to the enrollee;

10. "Group contract" means a contract for health care services which by its terms limits eligibility to members of a specified group. The group contract may include coverage for dependents;

11. "Group contract holder" means the person to which a group contract has been issued;

12. "Health maintenance organization" or "HMO" means a person that undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for copayments or deductibles for which the enrollee is responsible, or both;

13. "Health maintenance organization producer" means a person who solicits, negotiates, effects, procures, delivers, renews or continues a policy or contract for HMO membership, or who takes or transmits a membership fee or premium for such a policy or contract, other than for the person, or a person who advertises or otherwise holds himself or herself out to the public as a health maintenance organization producer;

14. "Individual contract" means a contract for health care services issued to and covering an individual. An individual contract may include the dependents of the subscriber;

15. "Insolvent" or "insolvency" means a process by which an organization has been declared insolvent and placed under an order of liquidation by a court of competent jurisdiction;

16. "Insurance Commissioner" means the Insurance Commissioner pursuant to the provisions of Title 36 of the Oklahoma Statutes;

17. "Managed hospital payment basis" means agreements wherein the financial risk is primarily related to the degree of utilization rather than to the cost of services;

18. "NAIC" means the National Association of Insurance Commissioners;

19. "Net worth" means the excess of total admitted assets over total liabilities, provided, total liabilities shall not include fully subordinated debt;

20. "Participating provider" means a provider as defined in paragraph 22 of this section who, under an express or implied

contract with the health maintenance organization, its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than copayment or deductible, directly or indirectly from the health maintenance organization;

21. "Person" means a natural or artificial person including, but not limited to, individuals, partnerships, associations, trusts or corporations;

22. "Provider" means a physician, hospital or other person licensed or otherwise authorized to furnish health care services;

23. "Replacement coverage" means the benefits provided by a succeeding carrier;

24. "State Commissioner of Health" means the State Commissioner of Health pursuant to the provisions of Section 1-106 of Title 63 of the Oklahoma Statutes;

25. "Subscriber" means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the health maintenance organization, or in the case of an individual contract, the person in whose name the contract is issued; and

26. "Uncovered expenditures" means the costs to the health maintenance organization for health care services that are the obligation of the health maintenance organization, for which an enrollee may also be liable in the event of the health maintenance organization's insolvency and for which no alternative arrangements have been made that are acceptable to the Insurance Commissioner. Added by Laws 2003, c. 197, § 2, eff. Nov. 1, 2003.

§36-6903. Certificate of authority - Application requirements - Submission to Insurance Commissioner - Rules.

A. Notwithstanding any law of this state to the contrary, any person may apply to the Insurance Commissioner for a certificate of authority to establish and operate a health maintenance organization pursuant to the provisions of the Health Maintenance Organization Act of 2003. No person shall establish or operate a health maintenance organization in this state without obtaining a certificate of authority pursuant to the provisions of this act. A foreign corporation may qualify under this act, subject to its registration to do business in this state as a foreign corporation and compliance with all provisions of this act and other applicable state laws. All certificates of authority shall be perpetual and automatically renewed as of March 1 of each year, unless the health maintenance organization fails to qualify for renewal pursuant to the provisions of this act and any other applicable provisions of Title 36 of the Oklahoma Statutes.

B. Any health maintenance organization that has previously received a certificate of authority from the State Commissioner of

Health, but has not received a certificate of authority from the Insurance Commissioner to operate as a health maintenance organization as of the effective date of this act shall submit an application for a certificate of authority, as provided in subsection C of this section, by March 1, 2004. Each applicant may continue to operate until such time as the Insurance Commissioner acts upon the application if the applicant continues to comply with the provisions of Title 63 of the Oklahoma Statutes, the rules promulgated pursuant thereto by the State Board of Health as they existed immediately prior to the effective date of this act, and administrative orders entered by the State Commissioner of Health prior to the effective date of this act. In the event that an application is denied under the provisions of Section 4 of this act, the applicant shall thereafter be treated as a health maintenance organization whose certificate of authority has been revoked.

C. Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the National Association of Insurance Commissioners (NAIC), and shall be accompanied by the following:

1. A copy of the applicant's organizational documents including, but not limited to, the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto;

2. A copy of the bylaws, rules, regulations or similar document, if any, regulating the conduct of the internal affairs of the applicant;

3. A list of the names, addresses, official positions and biographical information, on forms acceptable to the NAIC, of the persons who are to be responsible for the conduct of the affairs and day-to-day operations of the applicant, including all members of the board of directors, board of trustees, executive committee or other governing board or committee, and the principal officers in the case of a corporation, or the partners or members in the case of a partnership or association;

4. A copy of any contract form made or to be made between any class of providers and the health maintenance organization, and a copy of any contract made or to be made between third party administrators, marketing consultants or persons listed in paragraph 3 of this subsection and the health maintenance organization;

5. A copy of the form of evidence of coverage to be issued to enrollees;

6. A copy of the form of group contract, if any, to be issued to employers, unions, trustees or other organizations;

7. Financial statements showing the applicant's assets, liabilities and sources of financial support including, but not limited to:

- a. a copy of the applicant's most recent, regular certified financial statement,
- b. an unaudited current financial statement, and
- c. fully audited financial information as to the earnings and financial condition of each person controlling a domestic health maintenance organization pursuant to the provisions of subsection (c) of Section 1651 of Title 36 of the Oklahoma Statutes for the preceding five (5) fiscal years for each such acquiring party, or for such lesser period as such acquiring party and any predecessors thereof shall have been in existence, and similar unaudited information as of a date not earlier than ninety (90) days prior to the filing of the statement; provided, however, the Insurance Commissioner shall have the discretionary ability to waive the audit requirement based upon review of substantially similar financial disclosure statements submitted by the acquiring party;

8. A financial feasibility plan that includes detailed enrollment projections, the methodology for determining premium rates to be charged during the first twelve (12) months of operations as certified by an actuary or other qualified person acceptable to the Insurance Commissioner, a projection of balance sheets, cash flow statements showing any capital expenditures, purchase and sale of investments and deposits with the state, and income and expense statements anticipated from the start of operations until the organization has had net income for at least one year, and a statement as to the sources of working capital as well as any other sources of funding;

9. A power of attorney duly executed by the applicant, if not domiciled in this state, appointing the Insurance Commissioner, his or her successors in office and duly authorized deputies, as the true and lawful attorney of the applicant in and for this state upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this state may be served;

10. A statement or map reasonably describing the geographic area or areas to be served;

11. A description of the internal grievance procedures to be utilized for the investigation and resolution of enrollee complaints and grievances;

12. A description of the proposed quality assurance program, including the formal organizational structure, methods for developing criteria, procedures for comprehensive evaluation of the quality of care rendered to enrollees, and processes to initiate corrective action and reevaluation when deficiencies in provider or organizational performance are identified;

13. A description of the procedures to be implemented to meet the protection against insolvency provisions of Section 13 of this act;

14. A list of the names, addresses, and license numbers of all providers with which the health maintenance organization has agreements;

15. Other information the Insurance Commissioner may require to make the determinations required in Section 4 of this act; and

16. An original, along with copies, of all documents required pursuant to the provisions of this subsection, with all required fees.

D. 1. The Insurance Commissioner may promulgate rules for the proper administration of this act and to require a health maintenance organization, subsequent to receiving its certificate of authority, to submit the information, modifications or amendments to the items described in subsection C of this section to the Insurance Commissioner, either for approval or for information only, prior to the effectuation of the modification or amendment, or to require the health maintenance organization to indicate the modifications to both the State Commissioner of Health and the Insurance Commissioner at the time of the next succeeding site visit or examination.

2. Any modification or amendment for which the Insurance Commissioner's approval is required shall be deemed approved unless disapproved within thirty (30) days, provided that the Insurance Commissioner may postpone the action for such further time, not exceeding an additional sixty (60) days, as necessary for proper consideration.

Added by Laws 2003, c. 197, § 3, eff. Nov. 1, 2003.

§36-6903.1. Exemption of certain domestic health maintenance organizations from certain provisions of act.

Domestic health maintenance organizations that contract with the Oklahoma Health Care Authority to provide basic health services to Medicaid recipients and that do not provide basic health care services to any other group of persons shall be exempt from the provisions of Sections 6911, 6914, 6915 and 6932 of this title.

Added by Laws 2004, c. 146, § 1, eff. Nov. 1, 2004; Amended by Laws 2017, c. 287, § 6, eff. Nov. 1, 2017.

§36-6904. Certification by Insurance Commissioner - Issuance of certificate.

A. Upon receipt of an application for issuance of a certificate of authority, the Insurance Commissioner shall within forty-five (45) days determine whether the applicant, with respect to health care services to be furnished, has complied with the provisions of Section 6907 of this title.

B. The Insurance Commissioner shall, within forty-five (45) days of determining compliance or deficiency, issue a certificate of authority to a person filing a completed application upon receipt of the prescribed fees and upon the Insurance Commissioner's being satisfied that:

1. The persons responsible for the conduct of the affairs of the applicant are competent and trustworthy, and possess good reputations;

2. Any deficiency identified has been corrected and the Insurance Commissioner has determined that the health maintenance organization's proposed plan of operation meets the requirements of Section 6907 of this title;

3. The health maintenance organization will effectively provide or arrange for the provision of basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for copayments or deductibles, or both; and

4. The health maintenance organization is in compliance with the provisions of Sections 6913 and 6915 of this title.

C. A certificate of authority shall be denied only after the Insurance Commissioner complies with the requirements of Section 6920 of this act title. No other criteria may be used to deny a certificate of authority.

Added by Laws 2003, c. 197, § 4, eff. Nov. 1, 2003. Amended by Laws 2021, c. 478, § 36, emerg. eff. May 12, 2021.

§36-6905. Powers of health maintenance organization - Notice of effect on financial soundness.

A. The powers of a health maintenance organization (HMO) include, but are not limited to, the following:

1. The purchase, lease, construction, renovation, operation or maintenance of hospitals, medical facilities, or both, and their ancillary equipment and property reasonably required for its principal office or for purposes necessary to the transaction of the business of the organization;

2. Transactions between affiliated entities, including loans and the transfer of responsibility under all provider or subscriber contracts between affiliates or between the health maintenance organization and its parent;

3. The furnishing of health care services through providers, provider associations or agents for providers which are under contract with or employed by the health maintenance organization;

4. The contracting with a person for the performance on its behalf of certain functions such as marketing, enrollment and administration;

5. The contracting with an insurance company licensed in this state, or with a hospital or medical service corporation authorized

to do business in this state, for the provision of insurance, indemnity or reimbursement against the cost of health care services provided by the health maintenance organization;

6. The offering of other health care services in addition to basic health care services. Nonbasic health care services may be offered by a health maintenance organization on a prepaid basis without offering basic health care services to any group or individual; and

7. The joint marketing of products with an insurance company licensed in this state or with a hospital or medical service corporation authorized to do business in this state as long as the company that is offering each product is clearly identified.

B. 1. A health maintenance organization shall file notice, with adequate supporting information, with the Insurance Commissioner prior to the exercise of any power granted in paragraphs 1, 2 or 4 of subsection A of this section that may affect the financial soundness of the health maintenance organization. The Insurance Commissioner shall disapprove the exercise of power only if, in the Insurance Commissioner's opinion, it would substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations. If the Insurance Commissioner does not disapprove such exercise of power within sixty (60) days of the filing, it shall be deemed approved.

2. The Insurance Commissioner may promulgate rules exempting those activities having a de minimis effect from the filing requirement of paragraph 1 of this subsection.

Added by Laws 2003, c. 197, § 5, eff. Nov. 1, 2003.

§36-6906. Receipt, collection, disbursement or investment of funds - Fiduciary relationship - Fidelity bond or insurance.

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

B. A health maintenance organization shall maintain in force a fidelity bond or fidelity insurance on such employees, officers, directors and partners in an amount that is not less than Two Hundred Fifty Thousand Dollars (\$250,000.00) for each health maintenance organization, or a maximum of Five Million Dollars (\$5,000,000.00) in aggregate maintained on behalf of health maintenance organizations owned by a common parent corporation, or the sum prescribed by the Insurance Commissioner.

Added by Laws 2003, c. 197, § 6, eff. Nov. 1, 2003. Amended by Laws 2005, c. 129, § 19, eff. Nov. 1, 2005.

§36-6907. Reasonable standards of quality of care - Quality assurance plan and activities - Record of proceedings - Patient record system - Medical policy - Credentialing and recredentialing of health care providers - Termination or nonrenewal of contracts - Emergency services.

A. Every health maintenance organization shall establish procedures that ensure that health care services provided to enrollees shall be rendered under reasonable standards of quality of care consistent with prevailing professionally recognized standards of medical practice. The procedures shall include mechanisms to assure availability, accessibility and continuity of care.

B. The health maintenance organization shall have an ongoing internal quality assurance program to monitor and evaluate its health care services, including primary and specialist physician services and ancillary and preventive health care services across all institutional and noninstitutional settings. The program shall include, but need not be limited to, the following:

1. A written statement of goals and objectives that emphasizes improved health status in evaluating the quality of care rendered to enrollees;

2. A written quality assurance plan that describes the following:

- a. the health maintenance organization's scope and purpose in quality assurance,
- b. the organizational structure responsible for quality assurance activities,
- c. contractual arrangements, where appropriate, for delegation of quality assurance activities,
- d. confidentiality policies and procedures,
- e. a system of ongoing evaluation activities,
- f. a system of focused evaluation activities,
- g. a system for credentialing and recredentialing providers, and performing peer review activities, and
- h. duties and responsibilities of the designated physician responsible for the quality assurance activities;

3. A written statement describing the system of ongoing quality assurance activities including:

- a. problem assessment, identification, selection and study,
- b. corrective action, monitoring, evaluation and reassessment, and
- c. interpretation and analysis of patterns of care rendered to individual patients by individual providers;

4. A written statement describing the system of focused quality assurance activities based on representative samples of the enrolled

population that identifies method of topic selection, study, data collection, analysis, interpretation and report format; and

5. Written plans for taking appropriate corrective action whenever, as determined by the quality assurance program, inappropriate or substandard services have been provided or services that should have been furnished have not been provided.

C. The organization shall record proceedings of formal quality assurance program activities and maintain documentation in a confidential manner. Quality assurance program minutes shall be available to the Insurance Commissioner.

D. The organization shall ensure the use and maintenance of an adequate patient record system which will facilitate documentation and retrieval of clinical information for the purpose of the health maintenance organization's evaluating continuity and coordination of patient care and assessing the quality of health and medical care provided to enrollees.

E. Enrollee clinical records shall be available to the Insurance Commissioner or an authorized designee for examination and review to ascertain compliance with this section, or as deemed necessary by the Insurance Commissioner.

F. The organization shall establish a mechanism for periodic reporting of quality assurance program activities to the governing body, providers and appropriate organization staff.

G. The organization shall be required to establish a mechanism under which physicians participating in the plan may provide input into the plan's medical policy including, but not limited to, coverage of new technology and procedures, utilization review criteria and procedures, quality, credentialing and recredentialing criteria, and medical management procedures.

H. As used in this section "credentialing" or "recredentialing", as applied to physicians and other health care providers, means the process of accessing and validating the qualifications of such persons to provide health care services to the beneficiaries of a health maintenance organization. Credentialing or recredentialing may include, but need not be limited to, an evaluation of licensure status, education, training, experience, competence and professional judgment. Credentialing or recredentialing is a prerequisite to the final decision of a health maintenance organization to permit initial or continued participation by a physician or other health care provider.

1. Physician credentialing and recredentialing shall be based on criteria as provided in the uniform credentialing application required by Section 1-106.2 of Title 63 of the Oklahoma Statutes, with input from physicians and other health care providers.

2. Organizations shall make information on credentialing and recredentialing criteria available to physician applicants and other health care providers, participating physicians, and other

participating health care providers and shall provide applicants with a checklist of materials required in the application process.

3. When economic considerations are part of the credentialing and recredentialing decision, objective criteria shall be used and shall be available to physician applicants and participating physicians. When graduate medical education is a consideration in the credentialing and recredentialing process, equal recognition shall be given to training programs accredited by the Accrediting Council on Graduate Medical Education and by the American Osteopathic Association. When graduate medical education is considered for optometric physicians, consideration shall be given for educational accreditation by the Council on Optometric Education.

4. Physicians or other health care providers under consideration to provide health care services under a managed care plan in this state shall apply for credentialing and recredentialing on the uniform credentialing application and provide the documentation as outlined by the plan's checklist of materials required in the application process.

5. A health maintenance organization (HMO) shall determine whether a credentialing or recredentialing application is complete. If an application is determined to be incomplete, the plan shall notify the applicant in writing within ten (10) calendar days of receipt of the application. The written notice shall specify the portion of the application that is causing a delay in processing and explain any additional information or corrections needed.

6. In reviewing the application, the health maintenance organization (HMO) shall evaluate each application according to the plan's checklist of materials required in the application process.

7. When an application is deemed complete, the HMO shall initiate requests for primary source verification and malpractice history within seven (7) calendar days.

8. A malpractice carrier shall have twenty-one (21) calendar days within which to respond after receipt of an inquiry from a health maintenance organization (HMO). Any malpractice carrier that fails to respond to an inquiry within the allotted time frame may be assessed an administrative penalty by the Insurance Commissioner.

9. Upon receipt of primary source verification and malpractice history by the HMO, the HMO shall determine if the application is a clean application. If the application is deemed clean, the HMO shall have forty-five (45) calendar days within which to credential or recredential a physician or other health care provider. As used in this paragraph, "clean application" means an application that has no defect, misstatement of facts, improprieties, including a lack of any required substantiating documentation, or particular circumstance requiring special treatment that impedes prompt credentialing or recredentialing.

10. If a health maintenance organization is unable to credential or recredential a physician or other health care provider due to an application's not being clean, the HMO may extend the credentialing or recredentialing process for sixty (60) calendar days. At the end of sixty (60) calendar days, if the HMO is awaiting documentation to complete the application, the physician or other health care provider shall be notified of the delay by certified mail. The physician or other health care provider may extend the sixty-day period upon written notice to the HMO within ten (10) calendar days; otherwise the application shall be deemed withdrawn.

11. In no event shall the entire credentialing or recredentialing process exceed one hundred eighty (180) calendar days.

12. A health maintenance organization shall be prohibited from solely basing a denial of an application for credentialing or recredentialing on the lack of board certification or board eligibility and from adding new requirements solely for the purpose of delaying an application.

13. Any HMO that violates the provisions of this subsection may be assessed an administrative penalty by the Insurance Commissioner.

I. Health maintenance organizations shall not discriminate against enrollees with expensive medical conditions by excluding practitioners with practices containing a substantial number of these patients.

J. Health maintenance organizations shall, upon request, provide to a physician whose contract is terminated or not renewed for cause the reasons for termination or nonrenewal. Health maintenance organizations shall not contractually prohibit such requests.

K. No HMO shall engage in the practice of medicine or any other profession except as provided by law nor shall an HMO include any provision in a provider contract that precludes or discourages a health maintenance organization's providers from:

1. Informing a patient of the care the patient requires, including treatments or services not provided or reimbursed under the patient's HMO; or

2. Advocating on behalf of a patient before the HMO.

L. Decisions by a health maintenance organization 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.

M. Health maintenance organizations shall not deny an otherwise covered emergency service based solely upon lack of notification to the HMO.

N. Health maintenance organizations 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 HMO contract.

O. If within a period of thirty (30) minutes after receiving a request from a hospital emergency department for a specialty consultation, a health maintenance organization fails to identify an appropriate specialist who is available and willing to assume the care of the enrollee, the emergency department may arrange for emergency services by an appropriate specialist that are medically necessary to attain stabilization of an emergency medical condition, and the HMO shall not deny coverage for the services due to lack of prior authorization.

P. The reimbursement policies and patient transfer requirements of a health maintenance organization shall not, directly or indirectly, require a hospital emergency department or provider to violate the federal Emergency Medical Treatment and Active Labor Act. If a member of an HMO is transferred from a hospital emergency department facility to another medical facility, the HMO shall reimburse the transferring facility and provider for services provided to attain stabilization of the emergency medical condition of the member in accordance with the federal Emergency Medical Treatment and Active Labor Act.

Added by Laws 2003, c. 197, § 7, eff. Nov. 1, 2003. Amended by Laws 2021, c. 478, § 37, emerg. eff. May 12, 2021.

§36-6908. Group or individual contract - Delivery - Required provisions - Evidence of coverage - Filing and review of forms.

A. 1. Every group and individual contract holder is entitled to a group or individual contract which may be delivered through electronic means or methods; provided, a member may request a printed copy from the health maintenance organization if the member cannot view and print such electronic copy.

2. The contract shall not contain provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, or which encourage misrepresentation as defined by Articles 12 and 12A-1 of the Insurance Code.

3. The contract shall contain a clear statement of the following:

- a. the name and address of the health maintenance organization,
- b. eligibility requirements,
- c. benefits and services within the service area,
- d. emergency care benefits and services,
- e. out of area benefits and services, if any,
- f. copayments, deductibles or other out-of-pocket expenses,
- g. limitations and exclusions,
- h. enrollee termination,
- i. enrollee reinstatement, if any,
- j. claims procedures,
- k. enrollee grievance procedures,
- l. continuation of coverage,
- m. conversion,
- n. extension of benefits, if any,
- o. coordination of benefits, if applicable,
- p. subrogation, if any,
- q. description of the service area,
- r. entire contract provision,
- s. term of coverage,
- t. cancellation of group or individual contract holder,
- u. renewal,
- v. reinstatement of group or individual contract holder, if any,
- w. grace period, and
- x. conformity with state law.

An evidence of coverage may be filed as part of the group contract to describe the provisions required in this paragraph.

B. In addition to those provisions required in paragraph 3 of subsection A of this section, an individual contract shall provide for a ten-day period to examine and return the contract and to refund any premiums. If services were received during the ten-day period, and the subscriber returns the contract to receive a refund of the premium paid, he or she must pay for those services.

C. 1. Every subscriber shall receive an evidence of coverage from the group contract holder or the health maintenance organization.

2. The evidence of coverage shall not contain provisions or statements that are unfair, unjust, inequitable, misleading, deceptive, or that encourage misrepresentation as defined by Articles 12 and 12A-1 of the Insurance Code.

3. The evidence of coverage shall contain a clear statement of the provisions required in paragraph 3 of subsection A of this section.

D. Every health maintenance organization doing business in this state shall comply with the provisions of Article 36A of the Insurance Code.

E. No group or individual contract, evidence of coverage or amendment thereto, shall be delivered or issued for delivery in this state, unless its form has been filed with and approved by the Insurance Commissioner, subject to the provisions of subsections F and G of this section.

F. If an evidence of coverage issued pursuant to and incorporated in a contract issued in this state is intended for delivery in another state and the evidence of coverage has been approved for use in the state in which it is to be delivered, the evidence of coverage need not be submitted to the Insurance Commissioner of this state for approval.

G. 1. Every form required by this section shall be filed with the Insurance Commissioner not less than thirty (30) days prior to delivery or issue for delivery in this state. At any time during the initial thirty-day period, the Insurance Commissioner may extend the period for review an additional thirty (30) days. Notice of an extension shall be in writing. At the end of the review period, the form is deemed approved if the Insurance Commissioner has taken no action. The filer must notify the Insurance Commissioner in writing prior to using a form that is deemed approved.

2. At any time, after thirty (30) days' notice and for cause shown, the Insurance Commissioner may withdraw approval of a form, effective at the end of the thirty (30) days.

3. When a filing is disapproved or approval of a form is withdrawn, the Insurance Commissioner shall give the health maintenance organization written notice of the reasons for disapproval and in the notice shall inform the health maintenance organization that within thirty (30) days of receipt of the notice the health maintenance organization may request a hearing. A hearing shall be conducted within thirty (30) days after the Insurance Commissioner has received the request for hearing.

H. The Insurance Commissioner may require the submission of relevant information he or she deems necessary in determining whether to approve or disapprove a filing made pursuant to this section.

Added by Laws 2003, c. 197, § 8, eff. Nov. 1, 2003. Amended by Laws 2016, c. 68, § 1, eff. Nov. 1, 2016.

§36-6909. Reports and statements.

A. Every health maintenance organization shall annually, on or before the first day of March, file a report verified by at least two principal officers with the Insurance Commissioner covering the preceding calendar year. The report shall be on forms and shall include all forms prescribed by the National Association of

Insurance Commissioners (NAIC). The report shall be filed with the NAIC in electronic format, as approved by the NAIC, along with applicable fees. In addition, the health maintenance organization shall file with the Insurance Commissioner via electronic format and a paper copy by the first day of March, unless otherwise stated:

1. Audited financial statements on or before June 1;
2. An actuarial opinion prepared and signed by a qualified actuary;
3. A list of the providers who have executed a contract that complies with the provisions of paragraph 1 of subsection D of Section 13 of this act; and
4.
 - a. a description of the grievance procedures, and
 - b. the total number of grievances handled through these procedures, a compilation of the causes underlying those grievances, and a summary of the final disposition of those grievances.

B. Domestic health maintenance organizations shall file quarterly financial statements with the Insurance Commissioner on or before the forty-fifth day following the end of each calendar quarter other than the fourth quarter of each year. The report shall be on forms and shall include all forms prescribed by the NAIC. The report shall be filed with the NAIC in electronic format, as approved by the NAIC, along with applicable fees.

C. The Insurance Commissioner may require additional reports deemed necessary and appropriate to enable the Insurance Commissioner to carry out his or her duties under this act.

Added by Laws 2003, c. 197, § 9, eff. Nov. 1, 2003.

§36-6910. Information to be provided to subscribers.

Every health maintenance organization (HMO) shall:

1. Provide to its subscribers electronically or in paper copy a list of providers upon enrollment and make such list available electronically or in paper copy upon reenrollment; provided, a subscriber has submitted written assurances that the subscriber can view and print such electronic copy;
2. Provide to its subscribers notice of any material change in the operation of the organization that will affect them directly, no later than thirty (30) days after such change;
3. Immediately notify an enrollee in writing of the termination of the enrollee's primary care provider and shall provide assistance to the enrollee in transferring to another participating primary care provider; and
4. Provide to subscribers, electronically or in paper copy, information on:
 - a. how to obtain services,
 - b. where to obtain additional information on access to services, and

c. how to contact the HMO at no cost to the enrollee.
Added by Laws 2003, c. 197, § 10, eff. Nov. 1, 2003.

§36-6911. Grievance procedures.

A. Every health maintenance organization shall establish and maintain a grievance procedure that has been approved by the Insurance Commissioner to provide for the resolution of grievances initiated by enrollees. Such grievance procedure shall be approved by the Insurance Commissioner within thirty (30) days of submission. The health maintenance organization shall maintain a record of grievances received since the date of its last examination of grievances.

B. The Insurance Commissioner may examine the grievance procedures.

C. Health maintenance organizations shall comply with the requirements of an insurer as set out in Sections 1250.1 through 1250.16 of this title.

Added by Laws 2003, c. 197, § 11, eff. Nov. 1, 2003. Amended by Laws 2021, c. 478, § 38, emerg. eff. May 12, 2021.

§36-6912. Investment of funds.

With the exception of investments made in accordance with the provisions of paragraph 1 of subsection A of Section 5 of this act, the funds of a health maintenance organization shall be invested only in accordance with the provisions of Article 16 of the Insurance Code.

Added by Laws 2003, c. 197, § 12, eff. Nov. 1, 2003.

§36-6913. Minimum net worth required - Deposit with Insurance Commissioner - Determination of liabilities - Liability of subscriber for health maintenance organization's debts - Insolvency plan - Notice of termination of agreement.

A. 1. Before issuing any certificate of authority, the Insurance Commissioner shall require that the health maintenance organization have an initial net worth of One Million Five Hundred Thousand Dollars (\$1,500,000.00) and that the HMO shall thereafter maintain the minimum net worth required under paragraph 2 of this subsection.

2. Except as provided in paragraphs 3 and 4 of this subsection, every health maintenance organization shall maintain a minimum net worth equal to the greater of:

- a. One Million Five Hundred Thousand Dollars (\$1,500,000.00),
- b. two percent (2%) of annual premium revenues as reported on the most recent annual financial statement filed with the Commissioner on the first One Hundred Fifty Million Dollars (\$150,000,000.00) of premium and

one percent (1%) of annual premium on the premium in excess of One Hundred Fifty Million Dollars (\$150,000,000.00),

- c. an amount equal to the sum of three (3) months of uncovered health care expenditures as reported on the most recent financial statement filed with the Commissioner, or
- d. an amount equal to the sum of:
 - (1) eight percent (8%) of annual health care expenditures, except those paid on a capitated basis or managed hospital payment basis, as reported on the most recent financial statement filed with the Commissioner, and
 - (2) four percent (4%) of annual hospital expenditures paid on a managed hospital payment basis, as reported on the most recent financial statement filed with the Commissioner.

3. Every health maintenance organization licensed before November 1, 2003, shall maintain a minimum net worth of the greater of Seven Hundred Fifty Thousand Dollars (\$750,000.00) or:

- a. twenty-five percent (25%) of the amount required by paragraph 2 of this subsection by December 31, 2003,
- b. fifty percent (50%) of the amount required by paragraph 2 of this subsection by December 31, 2004,
- c. seventy-five percent (75%) of the amount required by paragraph 2 of this subsection by December 31, 2005, and
- d. one hundred percent (100%) of the amount required by paragraph 2 of this subsection by December 31, 2006.

- 4. a. In determining net worth, no debt shall be considered fully subordinated unless the subordination clause is in a form acceptable to the Commissioner. An interest obligation relating to the repayment of any subordinated debt shall be similarly subordinated.
- b. The interest expenses relating to the repayment of a fully subordinated debt shall be considered covered expenses.
- c. A debt incurred by a note meeting the requirements of this section, and otherwise acceptable to the Insurance Commissioner, shall not be considered a liability and shall be recorded as equity.

B. 1. Unless otherwise provided below, each health maintenance organization shall deposit with the Commissioner or, at the discretion of the Commissioner, with any organization or trustee acceptable to the Commissioner through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other measures that are acceptable to the Commissioner,

which at all times shall have a value of not less than Five Hundred Thousand Dollars (\$500,000.00).

2. The deposit shall be an admitted asset of the health maintenance organization in the determination of net worth.

3. All income from deposits shall be an asset of the organization. A health maintenance organization that has made a securities deposit may withdraw that deposit or any part thereof after making a substitute deposit of cash, securities, or any combination of these or other measures of equal amount and value. Any securities shall be approved by the Commissioner before being deposited or substituted.

4. The deposit shall be used to protect the interests of the health maintenance organization's enrollees and to ensure continuation of health care services to enrollees. If a health maintenance organization is placed in receivership or liquidation, the deposit shall be an asset subject to the provisions of the Uniform Insurers Liquidation Act.

5. The Insurance Commissioner may reduce or eliminate the deposit requirement if a health maintenance organization deposits with the Commissioner or other official body of the state or jurisdiction of domicile for the protection of all subscribers and enrollees of the health maintenance organization, wherever located, cash, acceptable securities or surety, and delivers to the Commissioner a certificate to that effect, duly authenticated by the appropriate state official holding the deposit.

C. 1. Every health maintenance organization shall, when determining liabilities, include an amount estimated in the aggregate to provide for:

- a. any unearned premium,
- b. the payment of all claims for incurred health care expenditures, whether reported or unreported, that are unpaid and for which the organization is or may be liable, and
- c. the expense of adjustment or settlement of those claims.

2. The liabilities shall be computed in accordance with rules promulgated by the Commissioner upon reasonable consideration of the ascertained experience and character of the health maintenance organization.

D. 1. Every contract between a health maintenance organization and a participating provider of health care services shall be in writing and shall provide that, in the event the health maintenance organization fails to pay for health care services as set forth in the contract, a subscriber or an enrollee shall not be liable to the provider for any sums owed by the health maintenance organization.

2. In the event that the participating provider contract has not been reduced to writing as required by this subsection or that

the contract fails to contain the required prohibition, the participating provider shall not collect or attempt to collect from a subscriber or an enrollee sums owed by the health maintenance organization.

3. No participating provider or the provider's agent, trustee or assignee may maintain an action at law against a subscriber or enrollee to collect sums owed by the health maintenance organization.

E. The Commissioner shall require that each health maintenance organization have a plan for handling insolvency that allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to subscribers or enrollees who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits. In considering such a plan, the Commissioner may require:

1. Insurance to cover the expenses to be paid for continued benefits after an insolvency;

2. Provisions in provider contracts that obligate the provider to provide services for the duration of the period after the health maintenance organization's insolvency for which premium payment has been made and until the enrollees' discharge from inpatient facilities;

3. Insolvency reserves;

4. Acceptable letters of credit; or

5. Any other arrangements to ensure continuation of benefits as specified above.

F. An agreement to provide health care services between a provider and a health maintenance organization shall require that if the provider terminates the agreement, the provider shall give the organization at least ninety (90) days' advance notice of such termination.

Added by Laws 2003, c. 197, § 13, eff. Nov. 1, 2003. Amended by Laws 2014, c. 275, § 19, eff. Nov. 1, 2014; Laws 2019, c. 384, § 13, eff. Nov. 1, 2019.

§36-6914. Repealed by Laws 2019, c. 384, § 14, eff. Nov. 1, 2019.

§36-6915. Insolvency - Replacement coverage - Reduction or exclusion of benefits.

A. 1. In the event of an insolvency of a commercial health maintenance organization, upon order of the Insurance Commissioner, all other carriers that participated in the enrollment process with the insolvent health maintenance organization at a group's last regular enrollment period shall offer the group's enrollees of the insolvent health maintenance organization a thirty-day enrollment period commencing upon the date of insolvency. Each carrier shall offer the enrollees of the insolvent health maintenance organization

the same coverages and rates offered to the enrollees of the group at its last regular enrollment period.

2. If no other carrier had been offered to some groups enrolled in the insolvent health maintenance organization, or if the Insurance Commissioner determines that the other health benefit plans lack sufficient health care delivery resources to ensure that health care services will be available and accessible to all of the group enrollees of the insolvent health maintenance organization, the Insurance Commissioner shall equitably allocate the insolvent health maintenance organization's group contracts for these groups among all health maintenance organizations that operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which a group or groups are so allocated shall offer the group or groups the health maintenance organization's existing coverage that is most similar to each group's coverage with the insolvent health maintenance organization, at rates determined in accordance with the successor health maintenance organization's existing rating methodology.

B. 1. "Discontinuance" means the termination of the contract between the group contract holder and a health maintenance organization due to the insolvency of the health maintenance organization, and does not refer to the termination of any agreement between any individual enrollee and the health maintenance organization.

2. Any carrier providing replacement coverage with respect to group hospital, medical or surgical expense or service benefits within a period of sixty-three (63) days from the date of discontinuance of a prior health maintenance organization contract or policy providing hospital, medical or surgical expense or service benefits shall, as of the effective date of the replacement coverage, cover all enrollees who were validly covered under the previous health maintenance organization contract or policy at the date of discontinuance and who would otherwise be eligible for coverage under the succeeding carrier's contract, regardless of any provisions of the contract relating to active employment, hospital confinement or pregnancy.

3. Except to the extent benefits for the condition would have been reduced or excluded under the prior carrier's contract or policy, no provision in a succeeding carrier's contract of replacement coverage that would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preexisted the effective date of the succeeding carrier's contract shall be applied with respect to those enrollees validly covered under the prior carrier's contract or policy on the date of discontinuance.

4. a. Upon being declared insolvent, a health maintenance organization shall provide to the Insurance Commissioner:
 - (1) the names of all known enrollees who were validly enrolled under the insolvent HMO's contract, or
 - (2) policy information on validly enrolled enrollees who are hospitalized or whose health conditions require continuity of care.
- b. The insolvent HMO shall continue to provide such information to the Insurance Commissioner throughout the period of time required to provide replacement coverage to the validly covered enrollees of the insolvent HMO.

Added by Laws 2003, c. 197, § 15, eff. Nov. 1, 2003.

§36-6916. Premium rates - Approval by Insurance Commissioner.

A. No premium rate may be used by a health maintenance organization until such time as a schedule of premium rates or methodology for determining premium rates has been filed with and approved by the Insurance Commissioner. Such premium rates shall be confidential and not subject to public disclosure.

B. Either a specific schedule of premium rates or a methodology for determining premium rates shall be established in accordance with actuarial principles for various categories of enrollees; provided, that the premium applicable to an enrollee shall not be individually determined based on the status of the enrollee's health. Provided further, that the premium rates shall not be excessive, inadequate, unfair or discriminatory. A certification by a qualified actuary or other qualified person acceptable to the Insurance Commissioner as to the appropriateness of the use of the methodology, based on reasonable assumptions, shall accompany the filing along with adequate supporting information.

C. The Insurance Commissioner shall approve the schedule of premium rates or methodology for determining premium rates if the requirements of subsection B of this section are met. If the Insurance Commissioner disapproves the filing, the Insurance Commissioner shall notify the health maintenance organization. In the notice, the Insurance Commissioner shall specify the reasons for disapproval. A hearing will be conducted within thirty (30) days after a request in writing by the person filing. If the Insurance Commissioner does not take action on the schedule or methodology within thirty (30) days of the filing of the schedule or methodology, it shall be deemed approved.

D. When contracting with educational entities within the meaning of Section 1306 of Title 74 of the Oklahoma Statutes, in setting health insurance premiums for active employees and for retirees under sixty-five (65) years of age, health maintenance

organizations shall set the monthly premium for active employees at a maximum of Ninety Dollars (\$90.00) less than the monthly premium for retirees under sixty-five (65) years of age.

Added by Laws 2003, c. 197, § 16, eff. Nov. 1, 2003.

§36-6917. Producer license - Exempted persons.

A. Health maintenance organization producers shall comply with all applicable statutes and provisions of Title 36 of the Oklahoma Statutes and rules relating to producer licensing, including the Oklahoma Producer Licensing Act.

B. The following persons shall not be required to hold a health maintenance organization producer license:

1. A regular salaried officer or employee of a health maintenance organization who devotes substantially all of his or her time to activities other than the taking or transmitting of applications or membership fees or premiums for health maintenance organization membership, or who receives no commission or other compensation directly dependent upon the business obtained, and who does not solicit or accept from the public applications for health maintenance organization membership;

2. Employers or their officers or employees or the trustees of an employee benefit plan to the extent that the employers, officers, employees or trustees are engaged in the administration or operation of a program of employee benefits involving the use of health maintenance organization memberships; provided, that the employers, officers, employees or trustees are not in any manner compensated directly or indirectly by the health maintenance organization issuing health maintenance organization memberships;

3. Banks or their officers and employees to the extent that the banks, officers and employees collect and remit charges by charging them against accounts of depositors on the orders of the depositors; or

4. A person or the employee of a person who has contracted to provide administrative, management or health care services to a health maintenance organization and who is compensated for those services by the payment of an amount calculated as a percentage of the revenues, net income or profit of the health maintenance organization, if that method of compensation is the sole basis for subjecting that person or the employee of the person to this act.

C. The Insurance Commissioner may by rule exempt certain classes of persons from the requirement of obtaining a license:

1. If the functions such persons perform do not require special competence, trustworthiness or the regulatory surveillance made possible by licensing; or

2. If other existing safeguards make regulation unnecessary.

Added by Laws 2003, c. 197, § 17, eff. Nov. 1, 2003.

§36-6918. Organizations permitted to organize and operate health maintenance organization - Contracts for insurance against cost of care provided.

A. An insurance company licensed in this state or a hospital or medical service corporation authorized to do business in this state may either directly or through a subsidiary or affiliate organize and operate a health maintenance organization pursuant to the provisions of this act. Notwithstanding any other law which may be inconsistent, any two or more insurance companies, hospital or medical service corporations, or subsidiaries or affiliates thereof may jointly organize and operate a health maintenance organization. The business of insurance is deemed to include the providing of health care by a health maintenance organization owned or operated by an insurer or its subsidiary.

B. Notwithstanding any provision of insurance and hospital or medical service corporation laws in Title 36 of the Oklahoma Statutes, an insurer or a hospital or medical service corporation may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through health maintenance organizations and to provide coverage in the event of the failure of the health maintenance organization to meet its obligations. The enrollees of a health maintenance organization constitute a permissible group under such laws. An insurer or a hospital or medical service corporation may make benefit payments to health maintenance organizations for health care services rendered by providers pursuant to such contracts.
Added by Laws 2003, c. 197, § 18, eff. Nov. 1, 2003.

§36-6919. Examination of affairs, programs, books, and records - Payment of expenses.

A. The Insurance Commissioner may make an examination of the affairs of any health maintenance organization, producers and providers with whom the organization has contracts, agreements or other arrangements pursuant to the provisions of Sections 309.1 through 309.7 of this title.

B. The Insurance Commissioner may require a health maintenance organization to contract for an examination concerning the quality assurance program of the health maintenance organization and of any providers with whom the organization has contracts, agreements or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this state, but not less frequently than once every three (3) years.

C. Every health maintenance organization and provider shall submit its books and records for examination and in every way facilitate the completion of an examination. For the purpose of an examination, the Insurance Commissioner may administer oaths to, and examine the officers and agents of the health maintenance

organization and the principals of the providers concerning their business.

D. Any health maintenance organization examined shall pay the proper charges incurred in such examination, including the actual expense of the Insurance Commissioner or the expenses and compensation of any authorized representative and the expense and compensation of assistants and examiners employed therein. All expenses incurred in such examination shall be verified by affidavit and a copy shall be filed in the office of the Insurance Commissioner.

E. In lieu of an examination, the Insurance Commissioner may accept the report of an examination made by the health maintenance organization regulatory entity of another state.

Added by Laws 2003, c. 197, § 19, eff. Nov. 1, 2003. Amended by Laws 2021, c. 478, § 39, emerg. eff. May 12, 2021.

§36-6920. Examination of affairs, programs, books, and records - Payment of expenses.

A. A certificate of authority issued under the Health Maintenance Organization Act of 2003 may be suspended or revoked, and an application for a certificate of authority may be denied, if the Insurance Commissioner finds that any of the following conditions exist:

1. The health maintenance organization (HMO) is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in any other information submitted under Section 6903 of this title, unless amendments to those submissions have been filed with and approved by the Insurance Commissioner;

2. The health maintenance organization issues an evidence of coverage or uses a schedule of charges for health care services that does not comply with the requirements of Sections 6908 and 6916 of this title;

3. The health maintenance organization does not provide or arrange for basic health care services;

4. The Insurance Commissioner determines that:

a. the health maintenance organization does not meet the requirements of Section 6907 of this title, or

b. the health maintenance organization is unable to fulfill its obligations to furnish health care services;

5. The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

6. The health maintenance organization has failed to correct, within the time frame prescribed by subsection C of this section,

any deficiency occurring due to the health maintenance organization's prescribed minimum net worth being impaired;

7. The health maintenance organization has failed to implement the grievance procedures required by Section 6911 of this title in a reasonable manner to resolve valid complaints;

8. The health maintenance organization, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner;

9. The continued operation of the health maintenance organization would be hazardous to its enrollees or to the public; or

10. The health maintenance organization has otherwise failed to comply with the provisions of the Health Maintenance Organization Act of 2003 or applicable rules promulgated by the Insurance Commissioner pursuant thereto.

B. In addition to or in lieu of suspension or revocation of a certificate of authority pursuant to the provisions of this section, an applicant or health maintenance organization who knowingly violates the provisions of this section may be subject to an administrative penalty of Five Thousand Dollars (\$5,000.00) for each occurrence.

C. The following shall apply when insufficient net worth is maintained:

1. Whenever the Insurance Commissioner finds that the net worth maintained by any health maintenance organization subject to the provisions of this act is less than the minimum net worth required to be maintained by Section 6913 of this title, the Insurance Commissioner shall give written notice to the health maintenance organization of the amount of the deficiency and require filing with the Insurance Commissioner a plan for correction of the deficiency that is acceptable to the Insurance Commissioner, and correction of the deficiency within a reasonable time, not to exceed sixty (60) days, unless an extension of time, not to exceed sixty (60) additional days, is granted by the Insurance Commissioner. A deficiency shall be deemed an impairment, and failure to correct the impairment in the prescribed time shall be grounds for suspension or revocation of the certificate of authority or for placing the health maintenance organization in conservation, rehabilitation or liquidation; or

2. Unless allowed by the Insurance Commissioner, no health maintenance organization or person acting on its behalf may, directly or indirectly, renew, issue or deliver any certificate, agreement or contract of coverage in this state, for which a premium is charged or collected, when the health maintenance organization writing the coverage is impaired, and the fact of impairment is known to the health maintenance organization or to the person; provided, however, the existence of an impairment shall not prevent

the issuance or renewal of a certificate, agreement or contract when the enrollee exercises an option granted under the plan to obtain a new, renewed or converted coverage.

D. A certificate of authority shall be suspended or revoked or an application or a certificate of authority denied or an administrative penalty imposed only after compliance with the requirements of this section.

1. Suspension or revocation of a certificate of authority, denial of an application, or imposition of an administrative penalty by the Insurance Commissioner, pursuant to the provisions of this section, shall be by written order and shall be sent to the health maintenance organization or applicant by certified or registered mail. The written order shall state the grounds, charges or conduct on which the suspension, revocation or denial or administrative penalty is based. The health maintenance organization or applicant may, in writing, request a hearing within thirty (30) days from the date of mailing of the order. If no written request is made, the order shall be final upon the expiration of thirty (30) days.

2. If the health maintenance organization or applicant requests a hearing pursuant to the provisions of this section, the Insurance Commissioner shall issue a written notice of hearing and send such notice to the health maintenance organization or applicant by certified or registered mail stating:

- a. a specific time for the hearing, which may not be less than twenty (20) nor more than thirty (30) days after mailing of the notice of hearing, and
- b. that any hearing shall be held at the office of the Insurance Commissioner.

After the hearing, or upon failure of the health maintenance organization to appear at the hearing, the Insurance Commissioner shall take whatever action is deemed necessary based on written findings. The Insurance Commissioner shall mail the decision to the health maintenance organization or applicant.

E. The provisions of the Administrative Procedures Act shall apply to proceedings under this section to the extent they are not in conflict with the provisions of Section 313 of this title.

F. If the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of suspension, enroll any additional enrollees except newborn children or other newly acquired dependents of existing enrollees, and shall not engage in any advertising or solicitation whatsoever.

G. If the certificate of authority of a health maintenance organization is revoked, the HMO shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the

organization. The HMO shall engage in no further advertising or solicitation whatsoever. The Insurance Commissioner may, by written order, permit further operation of the HMO if found to be in the best interests of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

Added by Laws 2003, c. 197, § 20, eff. Nov. 1, 2003. Amended by Laws 2021, c. 478, § 40, emerg. eff. May 12, 2021.

§36-6921. Repealed by Laws 2019, c. 384, § 14, eff. Nov. 1, 2019.

§36-6922. Order to rectify financial condition or violation - Required actions - Remedies and measures available to Insurance Commissioner.

A. Whenever the Insurance Commissioner determines that the financial condition of a health maintenance organization (HMO) is such that its continued operation might be hazardous to its enrollees, creditors or the general public, or that the HMO has violated any provision of the Health Maintenance Organization Act of 2003, the Insurance Commissioner may, after notice and opportunity for hearing, order the health maintenance organization to take action reasonably necessary to rectify the condition or violation including, but not limited, to one or more of the following:

1. Reduce the total amount of present and potential liability for benefits by reinsurance or other method acceptable to the Insurance Commissioner;
2. Reduce the volume of new business being accepted;
3. Reduce expenses by specified methods;
4. Suspend or limit the writing of new business for a period of time;
5. Increase the health maintenance organization's capital and surplus by contribution; or
6. Take other steps the Insurance Commissioner may deem appropriate under the circumstances.

B. For purposes of this section, the violation by a health maintenance organization of any law of this state to which the health maintenance organization is subject shall be deemed a violation of this act.

C. Rules of the Insurance Commissioner establishing criteria that the Insurance Commissioner may consider in making a determination that the condition of any insurer is such that continuation of such insurer's business may be hazardous to the public or to holders of its policies or certificates of insurance may be used by the Insurance Commissioner for early warning that the continued operation of any health maintenance organization might be hazardous to its enrollees, creditors, or the general public and to

set standards for evaluating the financial condition of any health maintenance organization.

D. The remedies and measures available to the Insurance Commissioner under this section shall be in addition to, and not in lieu of, the remedies and measures available to the Insurance Commissioner under the provisions of Section 1904 of Title 36 of the Oklahoma Statutes.

Added by Laws 2003, c. 197, § 22, eff. Nov. 1, 2003.

§36-6923. Rules.

The Insurance Commissioner may promulgate rules necessary or proper to carry out the provisions of the Health Maintenance Organization Act of 2003.

Added by Laws 2003, c. 197, § 23, eff. Nov. 1, 2003.

§36-6924. Payment of fees.

Every health maintenance organization subject to the provisions of the Health Maintenance Organization Act of 2003 shall pay to the Insurance Commissioner the fees provided in Section 321 of Title 36 of the Oklahoma Statutes.

Added by Laws 2003, c. 197, § 24, eff. Nov. 1, 2003.

§36-6925. Administrative penalty in lieu of suspension or revocation of certificate - Suspected violation - Order to cease and desist - Injunction.

A. The Insurance Commissioner may, in lieu of suspension or revocation of a certificate of authority under the provisions of Section 20 of this act, levy an administrative penalty against a health maintenance organization who knowingly violates the provisions of Section 20 of this act in an amount not to exceed Five Thousand Dollars (\$5,000.00) for each occurrence if reasonable notice in writing is given of the intent to levy the penalty and the health maintenance organization has a reasonable time within which to remedy the defect in its operations that gave rise to the penalty citation.

B. 1. If the Insurance Commissioner or the State Commissioner of Health shall for any reason have cause to believe that a violation of this act has occurred or is threatened, the Insurance Commissioner may give notice to the health maintenance organization and to the representatives, or other persons who appear to be involved in the suspected violation, to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to the suspected violation; and, in the event it appears that a violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing the violation.

2. Proceedings under this subsection shall not be governed by any formal procedural requirements, and may be conducted in such manner as the Insurance Commissioner or the State Commissioner of Health may deem appropriate under the circumstances; provided, however, unless consented to by the health maintenance organization, no order may result from a conference until the requirements of this section of this act are satisfied.

C. 1. The Insurance Commissioner may issue an order directing a health maintenance organization or a representative of a health maintenance organization to cease and desist from engaging in an act or practice in violation of the provisions of this act.

2. Within thirty (30) days after service of the cease and desist order, the respondent may request a hearing on the question of whether acts or practices in violation of this act have occurred. The hearing shall be conducted pursuant to Administrative Procedures Act and judicial review shall be available as provided by that act.

D. In the case of any violation of the provisions of this act, if the Insurance Commissioner elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued pursuant to the provisions of subsection C of this section, the Insurance Commissioner may institute a proceeding to obtain injunctive or other appropriate relief in the district court of Oklahoma County.

E. Notwithstanding any other provisions of this act, if a health maintenance organization fails to comply with the net worth requirement of this act, the Insurance Commissioner is authorized to take appropriate action to assure that the continued operation of the health maintenance organization will not be hazardous to its enrollees.

Added by Laws 2003, c. 197, § 25, eff. Nov. 1, 2003.

§36-6926. Provisions of laws not applicable to health maintenance organizations.

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

B. Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its

representatives, shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

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

Added by Laws 2003, c. 197, § 26, eff. Nov. 1, 2003. Amended by Laws 2005, c. 129, § 20, eff. Nov. 1, 2005.

§36-6927. Public records - Trade secrets - Privileged or confidential information.

All applications, filings, provider contracts excluding any financial terms and/or reimbursement criteria contained in such contracts, and reports required under the Health Maintenance Organization Act of 2003 shall be treated as public records, except those that are trade secrets or privileged or confidential quality assurance, commercial, financial or other information considered privileged or confidential under state or federal law, including, but not limited to, the Health Insurance Portability and Accountability Act (HIPAA). Annual financial statements that may be required under the provisions of Section 9 of this act shall be treated as public records.

Added by Laws 2003, c. 197, § 27, eff. Nov. 1, 2003.

§36-6928. Disclosure of diagnostic, treatment or health status information.

A. 1. Any data or information pertaining to the diagnosis, treatment or health of any enrollee or applicant obtained from that person or from a provider by a health maintenance organization shall be held in confidence and shall not be disclosed to any person except:

- a. to the extent that it may be necessary to carry out the purposes of the Health Maintenance Organization Act of 2003,
- b. upon the express consent of the enrollee or applicant,
- c. pursuant to statute or court order for the production of evidence or the discovery thereof, or
- d. in the event of claim or litigation between the person and the health maintenance organization wherein the data or information is pertinent.

2. A health maintenance organization shall be entitled to claim any statutory privileges against disclosure that the provider who furnished the information to the health maintenance organization is entitled to claim.

B. A person who, in good faith and without malice, takes an action or makes a decision or recommendation as a member, agent or employee of a health care review committee or who furnishes any

records, information or assistance to such a committee shall not be subject to liability for civil damages or any legal action in consequence of the action, nor shall the health maintenance organization that established the committee or the officers, directors, employees or agents of the health maintenance organization be liable for the activities of the person. This section shall not be construed to relieve any person of liability arising from treatment of a patient.

C. 1. The information considered by a health care review committee and the records of the committee's actions and proceedings shall be confidential and not subject to subpoena or order to produce except in proceedings before the appropriate state licensing or certifying agency, or in an appeal, if permitted, from the committee's findings or recommendations. No member of a health care review committee, or officer, director or other member of a health maintenance organization or its staff engaged in assisting a committee, or a person assisting or furnishing information to a committee may be subpoenaed to testify in any judicial or quasi-judicial proceeding if the subpoena is based solely on such activities.

2. Information considered by a health care review committee and the records of its actions and proceedings that are used pursuant to the provisions of paragraph 1 of this subsection by a state licensing or certifying agency or in an appeal shall be kept confidential and shall be subject to the same provisions concerning discovery and use in legal actions as the original information and records in the possession and control of a health care review committee.

D. To fulfill its obligations under Section 7 of this act, a health maintenance organization shall have access to treatment records and other information pertaining to the diagnosis, treatment or health status of an enrollee.

Added by Laws 2003, c. 197, § 28, eff. Nov. 1, 2003.

§36-6929. Contracts by Health Commissioner with qualified persons.

The Insurance Commissioner, in carrying out his or her obligations under the Health Maintenance Organization Act of 2003, may contract with qualified persons to make recommendations concerning the determinations required to be made by the Insurance Commissioner. The recommendations may be accepted in full or in part by the Insurance Commissioner. The Insurance Commissioner shall adopt procedures to ensure that such persons are not subject to a conflict of interest that would impair their ability to make recommendations in an impartial manner.

Added by Laws 2003, c. 197, § 29, eff. Nov. 1, 2003. Amended by Laws 2021, c. 478, § 41, emerg. eff. May 12, 2021.

§36-6930. Acquisition of control of health maintenance organization.

No person other than the issuer may make a tender for or a request or invitation for tenders of, or enter into an agreement to exchange securities for or acquire in the open market or otherwise, any voting security of a health maintenance organization or enter into any other agreement if, after the consummation thereof, that person would, directly or indirectly, or by conversion or by exercise of any right to acquire be in control of the health maintenance organization. No person may enter into an agreement to merge or consolidate with or otherwise to acquire control of a health maintenance organization, unless, at the time any offer, request or invitation is made or any agreement is entered into, or prior to the acquisition of the securities if no offer or agreement is involved, the person complied with the provisions of Article 16A of the Insurance Code.

Added by Laws 2003, c. 197, § 30, eff. Nov. 1, 2003.

§36-6931. Coordination of benefits provisions.

A. A health maintenance organization is permitted, but not required, to adopt coordination of benefits provisions to avoid over insurance and to provide for the orderly payment of claims when an enrollee is covered by two or more group health insurance or health care plans.

B. If a health maintenance organization adopts coordination of benefits, the provisions thereof shall be consistent with the coordination of benefits provisions that are in general use in the state for coordinating coverage between two or more group health insurance or health care plans.

C. To the extent necessary for a health maintenance organization to meet its obligations as a secondary carrier under the rules for coordination, a health maintenance organization may make payments for services that are:

1. Received from nonparticipating providers;
2. Provided outside its service areas; or
3. Not covered under the terms of its group contract or evidence of coverage.

Added by Laws 2003, c. 197, § 31, eff. Nov. 1, 2003.

§36-6932. Repealed by Laws 2019, c. 384, § 14, eff. Nov. 1, 2019.

§36-6933. Provision of basic health care services directly or by contract or agreement - Standards and procedures for selection of providers - Chiropractic and vision care services - Referrals.

A. A health maintenance organization shall provide basic health care services directly or by contract or agreement with other persons, corporations, institutions, associations, foundations or

other legal entities, public or private, in accordance with the laws governing such professions and services.

B. Each health maintenance organization shall have a defined set of standards and procedures for selecting providers, including specialists, to serve enrollees. The standards and procedures shall be drafted in such a manner as to be applicable to all categories of providers and shall be utilized by the health maintenance organization in a manner that is without bias for or discrimination against a particular category or categories of providers.

C. With respect to chiropractic services, such covered services shall be provided on a referral basis within the network at the request of an enrollee who has a condition of an orthopedic or neurological nature if:

1. A referral is necessitated in the judgment of the primary care physician; and

2. Treatment for the condition falls within the licensed scope of practice of a chiropractic physician.

D. 1. Any health maintenance organization that offers services for vision care or medical diagnosis and treatment for the eye shall allow optometrists to be providers of those services.

2. Once a fee schedule has been negotiated, ophthalmologists and optometrists shall be paid equally for the same services so long as the services provided by the optometrists are within the scope of the practice of optometry.

3. No health maintenance organization shall require a provider of vision care or medical diagnosis and treatment for the eye to have hospital privileges if hospital privileges are not usual and customary for the services the provider provides.

4. With respect to optometric services, such covered services shall be provided on a referral basis within the medical group or network at the request of an enrollee who has a condition requiring vision care or medical diagnosis and treatment of the eye if:

a. a referral is necessitated in the judgment of the primary care physician, and

b. treatment for the condition falls within the licensed scope of practice of an optometrist.

5. Nothing in this subsection shall be construed to:

a. prohibit any health maintenance organization that offers services for vision care or medical diagnosis and treatment for the eye from determining the adequacy of the size of its network,

b. limit, expand or otherwise affect the scope of practice of optometry, or

c. alter, repeal, modify or affect the laws of this state except where such laws are in conflict or are inconsistent with the express provisions of this section.

6. Existing contracts shall comply with the requirements of this subsection upon issuance or renewal on or after the effective date of this act.

E. 1. A health maintenance organization shall not:

- a. engage in the practice of medicine or any other profession except as provided by law, or
- b. prohibit or restrict a primary care physician from referring a patient to a specialist within the network if such referral is deemed medically necessary in the judgment of the primary care physician.

2. A health maintenance organization shall provide basic health care services in a manner that is reasonably geographically convenient to residents of the service area for which it seeks a license.

Added by Laws 2003, c. 197, § 33, eff. Nov. 1, 2003.

§36-6934. Services permitted to be provided.

Health maintenance organizations may provide any services included in state or federal health care programs, such as state employee benefits, the state basic health benefits program, "Medicare", "Medicaid", "CHAMPUS" and Veterans Administrations and other health programs provided in whole or in part by state or federal funds, in accordance with the laws governing such programs.

Added by Laws 2003, c. 197, § 34, eff. Nov. 1, 2003.

§36-6935. Services provided to out-of-state enrollees.

Basic health care services as herein provided may be furnished to enrollees of health maintenance organizations outside this state only in accordance with the laws of the state or of the United States that govern the provision of such services in the state or place concerned; provided, that an enrollee may be reimbursed directly for emergency health care expenses incurred by the enrollee while temporarily outside the state, when such expenses would have been provided under the enrollee's program had the enrollee been within the state. Such reimbursement made by a health maintenance organization shall not be construed as an indemnity and no health maintenance organization shall be an insurer or make any contract of insurance of any kind whatsoever.

Added by Laws 2003, c. 197, § 35, eff. Nov. 1, 2003.

§36-6936. Severability.

If any section, term or provision of this act shall be adjudged invalid for any reason, that judgment shall not affect, impair or invalidate any other section, term or provision of this act; but the remaining sections, terms and provisions shall be and remain in full force and effect.

Added by Laws 2003, c. 197, § 36, eff. Nov. 1, 2003.

§36-6937. Short title - Risk-based Capital (RBC) for Health Maintenance Organizations Act of 2003.

This act shall be known and may be cited as the "Risk-based Capital (RBC) for Health Maintenance Organizations Act of 2003". Added by Laws 2003, c. 197, § 37, eff. Nov. 1, 2003. Amended by Laws 2004, c. 146, § 2, eff. Nov. 1, 2004; Laws 2017, c. 287, § 7, eff. Nov. 1, 2017.

§36-6938. Definitions.

As used in the Risk-based Capital (RBC) for Health Maintenance Organizations Act of 2003:

1. "Adjusted Risk-based Capital (RBC) report" means an RBC report which has been adjusted by the Insurance Commissioner in accordance with the provisions of subsection C of Section 39 of this act;
2. "Corrective order" means an order issued by the Commissioner specifying corrective actions which the Insurance Commissioner has determined are required;
3. "Domestic health maintenance organization" means a health maintenance organization domiciled in this state;
4. "Foreign health maintenance organization" means a health maintenance organization that is licensed to do business in this state under the Health Maintenance Organization Act of 2003, but is not domiciled in this state;
5. "NAIC" means the National Association of Insurance Commissioners;
6. "Health maintenance organization" means a health maintenance organization licensed under the Health Maintenance Organization Act of 2003. This definition does not include an organization that is licensed as either a life and health insurer or a property and casualty insurer under Title 36 of the Oklahoma Statutes and that is otherwise subject to either life or property and casualty RBC requirements;
7. "RBC instructions" means the RBC report including risk-based capital instructions adopted by the NAIC, as these RBC instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC;
8. "RBC level" means a health maintenance organization's Company Action Level RBC, Regulatory Action Level RBC, Authorized Control Level RBC, or Mandatory Control Level RBC where:
 - a. "Company Action Level RBC" means, with respect to any health maintenance organization, the product of 2.0 and its Authorized Control Level RBC,
 - b. "Regulatory Action Level RBC" means the product of 1.5 and its Authorized Control Level RBC,

- c. "Authorized Control Level RBC" means the number determined under the risk-based capital formula in accordance with the RBC instructions, or
- d. "Mandatory Control Level RBC" means the product of .70 and the Authorized Control Level RBC;

9. "RBC plan" means a comprehensive financial plan containing the elements specified in subsection B of Section 40 of this act. If the Insurance Commissioner rejects the RBC plan, and it is revised by the health maintenance organization, with or without the Insurance Commissioner's recommendation, the plan shall be called the "revised RBC plan";

10. "RBC report" means the report required in Section 39 of this act; and

11. "Total adjusted capital" means the sum of:

- a. a health maintenance organization's statutory capital and surplus, or its net worth, as determined in accordance with the statutory accounting applicable to the annual financial statements required to be filed under Section 9 of this act, and
- b. such other items, if any, as the RBC instructions may provide.

Added by Laws 2003, c. 197, § 38, eff. Nov. 1, 2003.

§36-6939. Report of Risk-based Capital (RBC) levels - Formula - Adjustment by Commissioner.

A. A domestic health maintenance organization shall, on or prior to each March 1 filing date, prepare and submit to the Insurance Commissioner a report of its Risk-based Capital (RBC) levels as of the end of the calendar year just ended, in a form and containing such information as is required by the RBC instructions. In addition, a domestic health maintenance organization shall file its RBC report:

1. With the National Association of Insurance Commissioners (NAIC) in accordance with the RBC instructions; and

2. With the Insurance Commissioner in any state in which the health maintenance organization is authorized to do business, if the Insurance Commissioner has notified the health maintenance organization of its request in writing, in which case the health maintenance organization shall file its RBC report not later than the later of:

- a. fifteen (15) days from the receipt of notice to file its RBC report with that state, or
- b. the filing date.

B. A health maintenance organization's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take the following into account and may adjust for

the covariance between, determined in each case by applying the factors in the manner set forth in the RBC instructions:

1. Asset risk;
2. Credit risk;
3. Underwriting risk; and
4. All other business risks and such other relevant risks as are set forth in the RBC instructions.

C. If a domestic health maintenance organization files an RBC report that, in the judgment of the Commissioner, is inaccurate, the Commissioner shall adjust the RBC report to correct the inaccuracy and shall notify the health maintenance organization of the adjustment. The notice shall contain a statement of the reason for the adjustment. An RBC report as so adjusted is referred to as an "adjusted RBC report".

Added by Laws 2003, c. 197, § 39, eff. Nov. 1, 2003.

§36-6940. Company action level event - Definition - Submission of RBC plan - Insurance Commissioner's determination - Notice and hearing.

A. "Company Action Level Event" means any of the following events:

1. The filing of an RBC report by a health maintenance organization that indicates that the health maintenance organization's total adjusted capital is greater than or equal to its Regulatory Action Level RBC, but less than its Company Action Level RBC;

2. Notification by the Insurance Commissioner to the health maintenance organization of an adjusted RBC report that indicates an event in paragraph 1 of this subsection, provided the health maintenance organization does not challenge the adjusted RBC report under Section 6944 of this title;

3. If, pursuant to the provisions of Section 6944 of this title, a health maintenance organization challenges an adjusted RBC report that indicates the event in paragraph 1 of this subsection, the notification by the Commissioner to the health maintenance organization that the Commissioner has, after a hearing, rejected the health maintenance organization's challenge; or

4. If a health maintenance organization has total adjusted capital which is greater than or equal to its Company Action Level RBC but less than the product of its Authorized Control Level RBC and 3.0 and triggers the trend test determined in accordance with the trend test calculation included in the Health RBC instructions.

B. In the event of a Company Action Level Event, the health maintenance organization shall prepare and submit to the Commissioner an RBC plan that shall:

1. Identify the conditions that contribute to the Company Action Level Event;

2. Contain proposals of corrective actions that the health maintenance organization intends to take and that would be expected to result in the elimination of the Company Action Level Event;

3. Provide projections of the health maintenance organization's financial results in the current year and at least the two (2) succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory balance sheets, operating income, net income, capital and surplus, and RBC levels. The projections for both new and renewal business might include separate projections for each major line of business and separately identify each significant income, expense and benefit component;

4. Identify the key assumptions affecting the health maintenance organization's projections and the sensitivity of the projections to the assumptions; and

5. Identify the quality of, and problems associated with, the health maintenance organization's business including, but not limited to, its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance, if any, in each case.

C. The RBC plan shall be submitted:

1. Within forty-five (45) days of the Company Action Level Event; or

2. If the health maintenance organization challenges an adjusted RBC report pursuant to the provisions of Section 6944 of this title, within forty-five (45) days after notification to the health maintenance organization that the Commissioner has, after a hearing, rejected the health maintenance organization's challenge.

D. Within sixty (60) days after the submission by a health maintenance organization of an RBC plan to the Commissioner, the Commissioner shall notify the health maintenance organization whether the RBC plan will be implemented or whether, in the judgment of the Commissioner, the RBC plan is unsatisfactory. If the Commissioner determines that the RBC plan is unsatisfactory, the notification to the health maintenance organization shall state the reasons for the determination, and may list proposed revisions that will, in the judgment of the Commissioner, render the RBC plan satisfactory. Upon notification from the Commissioner, the health maintenance organization shall prepare a revised RBC plan, that may incorporate by reference any revisions proposed by the Commissioner, and shall submit the revised RBC plan to the Commissioner:

1. Within forty-five (45) days after the notification from the Commissioner; or

2. If the health maintenance organization challenges the notification from the Commissioner pursuant to the provisions of Section 6944 of this title, within forty-five (45) days after a notification to the health maintenance organization that the

Commissioner has, after a hearing, rejected the health maintenance organization's challenge.

E. In the event of a notification by the Commissioner to a health maintenance organization that the health maintenance organization's RBC plan or revised RBC plan is unsatisfactory, the Commissioner may, at the Commissioner's discretion and subject to the health maintenance organization's right to a hearing pursuant to the provisions of Section 6944 of this title, specify in the notification that the notification constitutes a Regulatory Action Level Event.

F. Every domestic health maintenance organization that files an RBC plan or revised RBC plan with the Commissioner shall file a copy of the RBC plan or revised RBC plan with the Insurance Commissioner in any state in which the health maintenance organization is authorized to do business if:

1. The state has an RBC provision substantially similar to subsection A of Section 6945 of this title; and

2. The Insurance Commissioner of that state has notified the health maintenance organization of its request for the filing in writing, in which case the health maintenance organization shall file a copy of the RBC plan or revised RBC plan in that state no later than the later of:

- a. fifteen (15) days after the receipt of notice to file a copy of its RBC plan or revised RBC plan with the state, or
- b. the date on which the RBC plan or revised RBC plan is filed under subsections C and D of this section.

Added by Laws 2003, c. 197, § 40, eff. Nov. 1, 2003. Amended by Laws 2011, c. 278, § 53, eff. Nov. 1, 2011.

§36-6941. Regulatory action level event - Definition - Duties of Insurance Commissioner - Challenge to adjusted RBC report or revised RBC plan - Use of actuaries, investment experts and other consultants.

A. "Regulatory Action Level Event" means, with respect to a health maintenance organization, any of the following events:

1. The filing of an RBC report by the health maintenance organization that indicates that the health maintenance organization's total adjusted capital is greater than or equal to its Authorized Control Level RBC but less than its Regulatory Action Level RBC;

2. Notification by the Commissioner to a health maintenance organization of an adjusted RBC report that indicates a Regulatory Action Level Event specified in paragraph 1 of this subsection, provided the health maintenance organization does not challenge the adjusted RBC report under Section 44 of this act;

3. If, pursuant to the provisions of Section 44 of this act, the health maintenance organization challenges an adjusted RBC report that indicates a Regulatory Action Level Event specified event in paragraph 1 of this subsection, the notification by the Commissioner to the health maintenance organization that the Commissioner has, after a hearing, rejected the health maintenance organization's challenge;

4. The failure of the health maintenance organization to file an RBC report by the filing date, unless the health maintenance organization has provided an explanation for the failure that is satisfactory to the Commissioner and has corrected the failure within ten (10) days after the filing date;

5. The failure of the health maintenance organization to submit an RBC plan to the Commissioner within the time period provided in subsection C of Section 40 of this act;

6. Notification by the Commissioner to the health maintenance organization that:

- a. the RBC plan or revised RBC plan submitted by the health maintenance organization is, in the judgment of the Commissioner, unsatisfactory, and
- b. notification constitutes a Regulatory Action Level Event with respect to the health maintenance organization, provided the health maintenance organization has not challenged the determination under Section 44 of this act;

7. If, pursuant to the provisions of Section 44 of this act, the health maintenance organization challenges a determination by the Commissioner under paragraph 6 of this subsection, the notification by the Commissioner to the health maintenance organization that the Commissioner has, after a hearing, rejected the challenge;

8. Notification by the Commissioner to the health maintenance organization that the health maintenance organization has failed to adhere to its RBC plan or revised RBC plan, but only if the failure has a substantial adverse effect on the ability of the health maintenance organization to eliminate the Company Action Level Event in accordance with its RBC plan or revised RBC plan and the Commissioner has so stated in the notification, provided the health maintenance organization has not challenged the determination under Section 44 of this act; or

9. If, pursuant to the provisions of Section 44 of this act, the health maintenance organization challenges a determination by the Commissioner under paragraph 8 of this subsection, the notification by the Commissioner to the health maintenance organization that the Commissioner has, after a hearing, rejected the challenge.

B. In the event of a Regulatory Action Level Event the Commissioner shall:

1. Require the health maintenance organization to prepare and submit an RBC plan or, if applicable, a revised RBC plan;

2. Perform such examination or analysis of the assets, liabilities and operations of the health maintenance organization as the Commissioner deems necessary, including a review of the HMO's RBC plan or revised RBC plan; and

3. Subsequent to the examination or analysis, issue a corrective order specifying such corrective actions as the Commissioner shall determine are required.

C. In determining corrective actions, the Commissioner may take into account factors the Commissioner deems relevant with respect to the health maintenance organization based upon the Commissioner's examination or analysis of the assets, liabilities and operations of the health maintenance organization including, but not limited to, the results of any sensitivity tests undertaken pursuant to the RBC instructions. The RBC plan or revised RBC plan shall be submitted:

1. Within forty-five (45) days after the occurrence of the Regulatory Action Level Event;

2. If the health maintenance organization challenges an adjusted RBC report pursuant to the provisions of Section 44 of this act and the challenge is not frivolous, in the judgment of the Commissioner, within forty-five (45) days after the notification to the health maintenance organization that the Commissioner has, after a hearing, rejected the health maintenance organization's challenge; or

3. If the health maintenance organization challenges a revised RBC plan pursuant to the provisions of Section 44 of this act and the challenge is not frivolous, in the judgment of the Commissioner, within forty-five (45) days after the notification to the health maintenance organization that the Commissioner has, after a hearing, rejected the health maintenance organization's challenge.

D. The Commissioner may retain such actuaries, investment experts and other consultants as may be necessary, in the judgment of the Commissioner, to review the health maintenance organization's RBC plan or revised RBC plan, examine or analyze the assets, liabilities and operations, including contractual relationships of the health maintenance organization, and formulate the corrective order with respect to the health maintenance organization. The fees, costs and expenses relating to consultants shall be borne by the affected health maintenance organization or such other party as directed by the Commissioner.

Added by Laws 2003, c. 197, § 41, eff. Nov. 1, 2003.

§36-6942. Authorized control level event - Definition - Duties of Insurance Commissioner.

A. "Authorized Control Level Event" means any of the following events:

1. The filing of an RBC report by the health maintenance organization that indicates that the health maintenance organization's total adjusted capital is greater than or equal to its Mandatory Control Level RBC, but less than its Authorized Control Level RBC;

2. The notification by the Commissioner to the health maintenance organization of an adjusted RBC report that indicates an Authorized Control Level Event as specified in paragraph 1 of this subsection, provided the health maintenance organization does not challenge the adjusted RBC report under Section 44 of this act;

3. If, pursuant to the provisions of Section 44 of this act, the health maintenance organization challenges an adjusted RBC report that indicates the event in paragraph 1 of this subsection, notification by the Commissioner to the health maintenance organization that the commissioner has, after a hearing, rejected the health maintenance organization's challenge;

4. The failure of the health maintenance organization to respond, in a manner satisfactory to the Commissioner, to a corrective order, provided the health maintenance organization has not challenged the corrective order under Section 44 of this act; or

5. If the health maintenance organization has challenged a corrective order under Section 44 of this act and the Commissioner has, after a hearing, rejected the challenge or modified the corrective order, the failure of the health maintenance organization to respond, in a manner satisfactory to the Commissioner, to the corrective order subsequent to rejection or modification by the Commissioner.

B. In the event of an Authorized Control Level Event with respect to a health maintenance organization, the Commissioner shall:

1. Take such actions as are required under Section 41 of this act regarding a health maintenance organization with respect to which a Regulatory Action Level Event has occurred; or

2. If the Commissioner deems it to be in the best interests of the policyholders and creditors of the health maintenance organization and of the public, take such actions as are necessary to cause the health maintenance organization to be placed under regulatory control pursuant to the provisions of Articles 18 and 19 of the Insurance Code. In the event the Commissioner takes such actions, the Authorized Control Level Event shall be deemed sufficient grounds for the Commissioner to take action pursuant to the provisions of Articles 18 and 19 of the Insurance Code, and the Commissioner shall have the rights, powers and duties with respect to the health maintenance organization as provided in Articles 18 and 19 of the Insurance Code.

Added by Laws 2003, c. 197, § 42, eff. Nov. 1, 2003.

§36-6943. Mandatory control level event - Definition - Duties of Insurance Commissioner.

A. "Mandatory Control Level Event" means any of the following events:

1. The filing of an RBC report which indicates that the health maintenance organization's total adjusted capital is less than its Mandatory Control Level RBC;

2. Notification by the Commissioner to the health maintenance organization of an adjusted RBC report that indicates a Mandatory Control Level Event specified in paragraph 1 of this subsection, provided the health maintenance organization does not challenge the adjusted RBC report under Section 44 of this act; or

3. If, pursuant to the provisions of Section 44 of this act, the health maintenance organization challenges an adjusted RBC report that indicates the event in paragraph 1 of this subsection, notification by the Commissioner to the health maintenance organization that the Commissioner has, after a hearing, rejected the health maintenance organization's challenge.

B. In the event of a Mandatory Control Level Event, the Commissioner shall take such actions as are necessary to place the health maintenance organization under regulatory control pursuant to the provisions of Articles 18 and 19 of the Insurance Code. In that event, the Mandatory Control Level Event shall be deemed sufficient grounds for the Commissioner to take action pursuant to the provisions of Articles 18 and 19 of the Insurance Code, and the Commissioner shall have the rights, powers and duties with respect to the health maintenance organization as provided in Articles 18 and 19 of the Insurance Code. Notwithstanding any of the preceding provisions, the Commissioner may forego action for up to ninety (90) days after the Mandatory Control Level Event if the Commissioner finds there is a reasonable expectation that the Mandatory Control Level Event may be eliminated within the ninety-day period.

Added by Laws 2003, c. 197, § 43, eff. Nov. 1, 2003.

§36-6944. Challenge of determination or action by Insurance Commissioner - Required events - Hearing.

Upon the occurrence of any of the events specified in this section, the health maintenance organization shall have the right to a confidential departmental hearing, on the record, at which time the health maintenance organization may challenge any determination or action by the Insurance Commissioner. The health maintenance organization shall notify the Commissioner of its request for a hearing within five (5) days after the notification by the Commissioner pursuant to the provisions of paragraph 1, 2, 3 or 4 of this section. Upon receipt of the health maintenance organization's

request for a hearing, the Commissioner shall set a date for the hearing, which shall be not less than ten (10), nor more than thirty (30) days after the date of the health maintenance organization's request. The events include:

1. Notification to a health maintenance organization by the Commissioner of an adjusted Risk-Based Capital (RBC) report;

2. Notification to a health maintenance organization by the Commissioner that:

a. the health maintenance organization's RBC plan or revised RBC plan is unsatisfactory, and

b. notification constitutes a Regulatory Action Level Event with respect to the health maintenance organization;

3. Notification to a health maintenance organization by the Commissioner that the health maintenance organization has failed to adhere to its RBC plan or revised RBC plan and that the failure has a substantial adverse effect on the ability of the health maintenance organization to eliminate the Company Action Level Event with respect to the health maintenance organization in accordance with its RBC plan or revised RBC plan; or

4. Notification to a health maintenance organization by the Commissioner of a corrective order with respect to the health maintenance organization.

Added by Laws 2003, c. 197, § 44, eff. Nov. 1, 2003.

§36-6945. Confidentiality of RBC reports and plans - Sharing and use of confidential information by Insurance Commissioner - Publication of RBC levels - Use of information in rate proceedings.

A. All Risk-Based Capital (RBC) reports, to the extent the information is not required to be provided in a publicly available annual statement schedule, and RBC plans, including the work papers produced, obtained by or disclosed to the Commissioner or any other person in the course of any examination or analysis and the results or report of any examination or analysis of a health maintenance organization performed pursuant to this statute and any corrective order issued by the Commissioner pursuant to examination or analysis, with respect to a domestic health maintenance organization or foreign health maintenance organization that are in the possession or control of the Insurance Commissioner shall, by law, be confidential and privileged, shall not be subject to the provisions of the Oklahoma Open Records Act or the Administrative Procedures Act, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action; provided, however, the Commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the Commissioner's official duties.

B. Access to the documentation provided for in subsection A of this section may be granted to the National Association of Insurance Commissioners. The parties shall agree in writing prior to receiving information to provide to it the same confidential treatment as required by this section, unless the prior written consent of the company to which it pertains has been obtained.

C. Neither the Commissioner nor any person who received documents, materials or other information while acting under the authority of the Commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials or information subject to the provisions of subsection A of this section.

D. In order to assist in the performance of the Commissioner's duties, the Commissioner:

1. May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to the provisions of subsection A of this section, with other state, federal and international regulatory agencies, with the NAIC and its affiliates and subsidiaries, and with state, federal and international law enforcement authorities; provided, that the recipient agrees to maintain the confidentiality and privileged status of the document, material or other information;

2. May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the NAIC and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

3. May enter into agreements governing the sharing and use of information consistent with this subsection.

E. No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the Commissioner under this section or as a result of sharing as authorized in paragraph 3 of subsection D of this section.

F. Except as otherwise required under the provisions of this act, the making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly to be made, published, disseminated, circulated or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over a radio or television station, or in any other way, an advertisement, announcement or statement containing an assertion, representation or

statement with regard to the RBC levels of any health maintenance organization, or of any component derived in the calculation, by any health maintenance organization, agent, broker or other person engaged in any manner in the insurance business would be misleading and is therefore prohibited. Provided, however, that if any materially false statement with respect to the comparison regarding a health maintenance organization's total adjusted capital to its RBC levels, or any of them, or an inappropriate comparison of any other amount to the health maintenance organization's RBC levels is published in any written publication and the health maintenance organization is able to demonstrate to the Commissioner with substantial proof the falsity or inappropriateness of the statement, the health maintenance organization may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

G. RBC instructions, RBC reports, adjusted RBC reports, RBC plans and revised RBC plans shall be used by the Commissioner solely in monitoring the solvency of health maintenance organizations and the need for possible corrective action with respect to health maintenance organizations. Such instructions, reports and plans shall not be used by the Commissioner for ratemaking, considered or introduced as evidence in any rate proceeding, or used by the Commissioner to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance that a health maintenance organization or any affiliate is authorized to write.

Added by Laws 2003, c. 197, § 45, eff. Nov. 1, 2003. Amended by Laws 2010, c. 356, § 7, eff. Nov. 1, 2010.

§36-6946. Application of act - Rules for implementation of act.

A. The provisions of the Risk-based Capital (RBC) for Health Maintenance Organizations Act of 2003 are supplemental to any other provisions of the laws of this state, and shall not preclude or limit any other powers or duties of the Insurance Commissioner under such laws including, but not limited to, Articles 18 and 19 of the Insurance Code and promulgated rules related to health maintenance organizations in hazardous financial condition.

B. The Commissioner may adopt reasonable rules necessary for the implementation of this act.

C. The Commissioner may exempt from the application of this act a domestic health maintenance organization that:

1. Writes direct business only in this state; and
2. Assumes no reinsurance in excess of five percent (5%) of direct premium written.

Added by Laws 2003, c. 197, § 46, eff. Nov. 1, 2003. Amended by Laws 2004, c. 146, § 3, eff. Nov. 1, 2004.

§36-6947. Foreign health maintenance organizations.

A. 1. A foreign health maintenance organization shall, upon the written request of the Insurance Commissioner, submit to the Commissioner a Risk-Based Capital (RBC) report as of the end of the calendar year just ended the later of:

- a. the date an RBC report would be required to be filed by a domestic health maintenance organization under this act, or
- b. fifteen (15) days after the request is received by the foreign health maintenance organization.

2. A foreign health maintenance organization shall, at the written request of the Commissioner, promptly submit to the Commissioner a copy of any RBC plan that is filed with the Insurance Commissioner of any other state.

B. In the event of a Company Action Level Event, Regulatory Action Level Event or Authorized Control Level Event with respect to a foreign health maintenance organization, as determined under the RBC statute applicable in the state of domicile of the health maintenance organization or, if no RBC statute is in force in that state, under the provisions of this act, if the Insurance Commissioner of the state of domicile of the foreign health maintenance organization fails to require the foreign health maintenance organization to file an RBC plan in the manner specified under that state's RBC statute or, if no RBC statute is in force in that state, under the provisions of Section 40 of this act, the Commissioner may require the foreign health maintenance organization to file an RBC plan with the Commissioner. In such event, the failure of the foreign health maintenance organization to file an RBC plan with the Commissioner shall be grounds to order the health maintenance organization to cease and desist from writing new insurance business in this state.

C. In the event of a Mandatory Control Level Event with respect to a foreign health maintenance organization, if no domiciliary receiver has been appointed for the foreign health maintenance organization under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign health maintenance organization, the Commissioner may make application to the District Court of Oklahoma County as permitted under Article 19 of the Insurance Code with respect to the liquidation of property of foreign health maintenance organizations found in this state, and the occurrence of the Mandatory Control Level Event shall be considered adequate grounds for the application.

Added by Laws 2003, c. 197, § 47, eff. Nov. 1, 2003.

§36-6948. Immunity from liability on part of Insurance Commissioner or Insurance Department or its employees or agents.

There shall be no liability on the part of, and no cause of action shall arise against, the Insurance Commissioner or the Insurance Department or its employees or agents for any action taken by them in the performance of their powers and duties under the Risk-based Capital (RBC) for Health Maintenance Organizations Act of 2003.

Added by Laws 2003, c. 197, § 48, eff. Nov. 1, 2003.

§36-6949. Severability.

If any provision of the Risk-based Capital (RBC) for Health Maintenance Organizations Act of 2003 or its application to any person or circumstance is held invalid, such determination shall not affect the provisions or applications of this act that can be given effect without the invalid provision or application, and to that end the provisions of this act are severable.

Added by Laws 2003, c. 197, § 49, eff. Nov. 1, 2003.

§36-6950. Effective date of notices by Insurance Commissioner.

All notices by the Insurance Commissioner to a health maintenance organization that may result in regulatory action under this act shall be effective upon the date the notice is postmarked by the United States Postal Service if transmitted by registered or certified mail or, in the case of any other transmission, shall be effective upon the health maintenance organization's receipt of notice.

Added by Laws 2003, c. 197, § 50, eff. Nov. 1, 2003.

§36-6951. Requirements for RBC reports filed in 2003.

For Risk-based Capital (RBC) reports required to be filed by health maintenance organizations in 2003, the following requirements shall apply in lieu of the provisions of Sections 40, 41, 42 and 43 of this act:

1. In the event of a Company Action Level Event in a domestic health maintenance organization, the Insurance Commissioner shall take no regulatory action under this act;

2. In the event of a Regulatory Action Level Event under the provisions of paragraphs 1, 2 or 3 of subsection A of Section 41 of this act the Commissioner shall take the actions required under Section 40 of this act;

3. In the event of a Regulatory Action Level Event under paragraphs 4, 5, 6, 7, 8 or 9 of subsection A of Section 41 of this act or an Authorized Control Level Event, the Commissioner shall take the actions required under Section 41 of this act; or

4. In the event of a Mandatory Control Level Event in a health maintenance organization, the Commissioner shall take the actions required under Section 42 of this act.

Added by Laws 2003, c. 197, § 51, eff. Nov. 1, 2003.

§36-6952. Nonprofit health maintenance organizations.

A. Nonprofit charitable and benevolent health maintenance organization corporations may hereafter be organized under the laws of the State of Oklahoma for the purpose of establishing, maintaining and operating a nonprofit health maintenance organization by complying with the provisions of this act.

B. Existing Oklahoma-licensed domestic health maintenance organizations may amend their corporate organizational documents to become nonprofit health maintenance organization corporations pursuant to the provisions of this act, which shall entitle them to all rights, obligations and provisions of this act. Existing Oklahoma-licensed domestic health maintenance organizations that amend their corporate organizational documents to become nonprofit health maintenance organization corporations shall continue to exist without interruption in business, licenses, certifications or other continuity.

C. The Oklahoma Insurance Commissioner may first approve the amended Certificate of Incorporation and the amended Business Plan of an existing Oklahoma-licensed domestic health maintenance organization subject to Section 3 of this act.

Added by Laws 2014, c. 272, § 1, eff. July 1, 2014.

§36-6953. Certificate of authority to issue contracts.

A nonprofit health maintenance organization corporation may issue contracts to its subscribers only when the Insurance Commissioner has, by certificate of authority, authorized it to do so. Application for such certificate of authority shall be made on forms supplied or approved by the Commissioner, containing such information as the Commissioner shall deem necessary. Each application for a certificate of authority shall be accompanied by copies of the documents required by Section 6903 of Title 36 of the Oklahoma Statutes.

Added by Laws 2014, c. 272, § 2, eff. July 1, 2014.

§36-6954. Application for certificate of authority - Requirements.

The Insurance Commissioner may certify nonprofit health maintenance organization corporations by issuing a certificate of authority, authorizing the applicant to issue contracts to its subscribers, when it is shown to the satisfaction of the Commissioner that:

1. The applicant is established as a bona fide nonprofit health maintenance organization corporation;

2. The contracts between the applicant and the participating physicians or other providers of health services obligate each provider executing the same to render service to which each

subscriber may be entitled under the terms of the contract to be issued to the subscribers;

3. The amount of required working capital of the corporation is paid into the corporation and, if subject to repayment, can be repaid only out of operating income, without endangering the solvency or financial strength of the nonprofit health maintenance organization corporation; and

4. The nonprofit corporation has met, or will be able to meet, the requirements set forth in the Health Maintenance Organization Act of 2003 and the risk-based capital for the Health Maintenance Organization Act of 2003.

Added by Laws 2014, c. 272, § 3, eff. July 1, 2014.

§36-6955. Transfers for existing health maintenance organizations to nonprofit status.

Any existing Oklahoma licensed domestic health maintenance organization that amends its Certificate of Incorporation and is approved as a nonprofit health maintenance organization corporation by the Insurance Commissioner may utilize its existing contracts, forms and rates already on file with the Commissioner.

Added by Laws 2014, c. 272, § 4, eff. July 1, 2014.

§36-6956. Private or publicly owned nonprofits - Application of Health Maintenance Organization Act of 2003 and rules to nonprofits.

A nonprofit health maintenance organization corporation may be privately or publicly owned. All of the requirements of the Health Maintenance Organization Act of 2003, the risk-based capital for the Health Maintenance Organization Act of 2003 and any rules promulgated thereunder shall be applicable to nonprofit health maintenance organization corporations, except that such corporations shall use their income and profit to further facilitate the providing of health care services to the public after paying expenses of operation and ownership.

Added by Laws 2014, c. 272, § 5, eff. July 1, 2014.

§36-6957. Scope of act.

The provisions of this act shall govern and apply only to nonprofit health maintenance organization corporations. Such corporations shall comply with all other laws applicable to health maintenance organizations under Title 36 of the Oklahoma Statutes and any rules promulgated thereunder.

Added by Laws 2014, c. 272, § 6, eff. July 1, 2014.

§36-6958. Short title - Patient's Right to Pharmacy Choice Act.

This act shall be known and may be cited as the "Patient's Right to Pharmacy Choice Act".

Added by Laws 2019, c. 426, § 1, eff. Nov. 1, 2019.

§36-6959. Purpose of act.

The purpose of the Patient's Right to Pharmacy Choice Act is to establish minimum and uniform access to a provider and standards and prohibitions on restrictions of a patient's right to choose a pharmacy provider.

Added by Laws 2019, c. 426, § 2, eff. Nov. 1, 2019.

§36-6960. Definitions.

A. For purposes of the Patient's Right to Pharmacy Choice Act:

1. "Covered entity" means a nonprofit hospital or medical service organization, for-profit hospital or medical service organization, insurer, health benefit plan, health maintenance organization, health program administered by the state in the capacity of providing health coverage, or an employer, labor union, or other group of persons that provides health coverage to persons in this state. This term does not include a health plan that provides coverage only for accidental injury, specified disease, hospital indemnity, disability income, or other limited benefit health insurance policies and contracts that do not include prescription drug coverage;

2. "Health insurer" means any corporation, association, benefit society, exchange, partnership or individual licensed by the Oklahoma Insurance Code;

3. "Health insurer payor" means a health insurance company, health maintenance organization, union, hospital and medical services organization or any entity providing or administering a self-funded health benefit plan;

4. "Mail-order pharmacy" means a pharmacy licensed by this state that primarily dispenses and delivers covered drugs via common carrier;

5. "Pharmacy benefits manager" or "PBM" means a person, business, or other entity that performs pharmacy benefits management. The term shall include a person or entity acting on behalf of a PBM in a contractual or employment relationship in the performance of pharmacy benefits management for a managed care company, nonprofit hospital, medical service organization, insurance company, third-party payor or a health program administered by a department of this state;

6. "Pharmacy benefits management" means a service provided to covered entities to facilitate the provisions of prescription drug benefits to covered individuals within the state, including, but not limited to, negotiating pricing and other terms with drug manufacturers and providers. Pharmacy benefits management may include any or all of the following services:

- a. claims processing, retail network management, and payment of claims to pharmacies for prescription drugs dispensed to covered individuals,
- b. administration or management of pharmacy discount cards or programs,
- c. clinical formulary development and management services, or
- d. rebate contracting and administration;

7. "Provider" means a pharmacy, as defined in Section 353.1 of Title 59 of the Oklahoma Statutes or an agent or representative of a pharmacy;

8. "Retail pharmacy network" means retail pharmacy providers contracted with a PBM in which the pharmacy primarily fills and sells prescriptions via a retail, storefront location;

9. "Rural service area" means a five-digit ZIP code in which the population density is less than one thousand (1,000) individuals per square mile;

10. "Spread pricing" means a prescription drug pricing model utilized by a pharmacy benefits manager in which the PBM charges a health benefit plan a contracted price for prescription drugs that differs from the amount the PBM directly or indirectly pays the pharmacy or pharmacist for providing pharmacy services;

11. "Suburban service area" means a five-digit ZIP code in which the population density is between one thousand (1,000) and three thousand (3,000) individuals per square mile; and

12. "Urban service area" means a five-digit ZIP code in which the population density is greater than three thousand (3,000) individuals per square mile.

B. Nothing in the definitions of pharmacy benefits manager or pharmacy benefits management as such terms are defined in the Patient's Right to Pharmacy Choice Act, the Pharmacy Audit Integrity Act, or Sections 357 through 360 of Title 59 of the Oklahoma Statutes shall be construed to deem the following entities to be a pharmacy benefits manager:

1. An employer of its own self-funded health benefit plan, except, to the extent permitted by applicable law, where the employer without the utilization of a third party and unrelated to the employer's own pharmacy:

- a. negotiates directly with drug manufacturers,
- b. processes claims on behalf of its members, or
- c. manages its own retail network of pharmacies; or

2. A pharmacy that provides a patient with a discount card or program that is for exclusive use at the pharmacy offering the discount.

Added by Laws 2019, c. 426, § 3, eff. Nov. 1, 2019. Amended by Laws 2022, c. 38, § 1, emerg. eff. April 21, 2022; Laws 2024, c. 306, § 1, emerg. eff. May 15, 2024.

§36-6961. Retail pharmacy network access standards.

A. Pharmacy benefits managers (PBMs) shall comply with the following retail pharmacy network access standards:

1. At least ninety percent (90%) of covered individuals residing in an urban service area live within two (2) miles of a retail pharmacy participating in the PBM's retail pharmacy network;

2. At least ninety percent (90%) of covered individuals residing in an urban service area live within five (5) miles of a retail pharmacy designated as a preferred participating pharmacy in the PBM's retail pharmacy network;

3. At least ninety percent (90%) of covered individuals residing in a suburban service area live within five (5) miles of a retail pharmacy participating in the PBM's retail pharmacy network;

4. At least ninety percent (90%) of covered individuals residing in a suburban service area live within seven (7) miles of a retail pharmacy designated as a preferred participating pharmacy in the PBM's retail pharmacy network;

5. At least seventy percent (70%) of covered individuals residing in a rural service area live within fifteen (15) miles of a retail pharmacy participating in the PBM's retail pharmacy network; and

6. At least seventy percent (70%) of covered individuals residing in a rural service area live within eighteen (18) miles of a retail pharmacy designated as a preferred participating pharmacy in the PBM's retail pharmacy network.

B. Mail-order pharmacies shall not be used to meet access standards for retail pharmacy networks.

C. Pharmacy benefits managers shall not require patients to use pharmacies that are directly or indirectly owned by the pharmacy benefits manager, including all regular prescriptions, refills or specialty drugs regardless of day supply.

D. Pharmacy benefits managers shall not in any manner on any material, including but not limited to mail and ID cards, include the name of any pharmacy, hospital or other providers unless it specifically lists all pharmacies, hospitals and providers participating in the preferred and nonpreferred pharmacy and health networks.

Added by Laws 2019, c. 426, § 4, eff. Nov. 1, 2019.

§36-6962. Compliance review.

A. The Attorney General shall review and approve retail pharmacy network access for all pharmacy benefits managers (PBMs) to ensure compliance with Section 6961 of this title.

B. A PBM, or an agent of a PBM, shall not:

1. Cause or knowingly permit the use of advertisement, promotion, solicitation, representation, proposal or offer that is untrue, deceptive or misleading;

2. Charge a pharmacist or pharmacy a fee related to the adjudication of a claim including without limitation a fee for:

- a. the submission of a claim,
- b. enrollment or participation in a retail pharmacy network, or
- c. the development or management of claims processing services or claims payment services related to participation in a retail pharmacy network;

3. Reimburse a pharmacy or pharmacist in the state an amount less than the amount that the PBM reimburses a pharmacy owned by or under common ownership with a PBM for providing the same covered services. The reimbursement amount paid to the pharmacy shall be equal to the reimbursement amount calculated on a per-unit basis using the same generic product identifier or generic code number paid to the PBM-owned or PBM-affiliated pharmacy;

4. Deny a provider the opportunity to participate in any pharmacy network at preferred participation status if the provider is willing to accept the terms and conditions that the PBM has established for other providers as a condition of preferred network participation status;

5. Deny, limit or terminate a provider's contract based on employment status of any employee who has an active license to dispense, despite probation status, with the State Board of Pharmacy;

6. Retroactively deny or reduce reimbursement for a covered service claim after returning a paid claim response as part of the adjudication of the claim, unless:

- a. the original claim was submitted fraudulently, or
- b. to correct errors identified in an audit, so long as the audit was conducted in compliance with Sections 356.2 and 356.3 of Title 59 of the Oklahoma Statutes;

7. Fail to make any payment due to a pharmacy or pharmacist for covered services properly rendered in the event a PBM terminates a provider from a pharmacy benefits manager network;

8. Conduct or practice spread pricing, as defined in Section 6960 of this title, in this state; or

9. Charge a pharmacist or pharmacy a fee related to participation in a retail pharmacy network including but not limited to the following:

- a. an application fee,
- b. an enrollment or participation fee,
- c. a credentialing or re-credentialing fee,
- d. a change of ownership fee, or

- e. a fee for the development or management of claims processing services or claims payment services.

C. The prohibitions under this section shall apply to contracts between pharmacy benefits managers and providers for participation in retail pharmacy networks.

1. A PBM contract shall:

- a. not restrict, directly or indirectly, any pharmacy that dispenses a prescription drug from informing, or penalize such pharmacy for informing, an individual of any differential between the individual's out-of-pocket cost or coverage with respect to acquisition of the drug and the amount an individual would pay to purchase the drug directly, and
- b. ensure that any entity that provides pharmacy benefits management services under a contract with any such health plan or health insurance coverage does not, with respect to such plan or coverage, restrict, directly or indirectly, a pharmacy that dispenses a prescription drug from informing, or penalize such pharmacy for informing, a covered individual of any differential between the individual's out-of-pocket cost under the plan or coverage with respect to acquisition of the drug and the amount an individual would pay for acquisition of the drug without using any health plan or health insurance coverage.

2. A pharmacy benefits manager's contract with a provider shall not prohibit, restrict, or limit disclosure of information or documents to the Attorney General, law enforcement or state and federal governmental officials investigating or examining a complaint or conducting a review of a pharmacy benefits manager's compliance with the requirements under the Patient's Right to Pharmacy Choice Act, the Pharmacy Audit Integrity Act, and Sections 357 through 360 of Title 59 of the Oklahoma Statutes.

D. A pharmacy benefits manager shall:

1. Establish and maintain an electronic claim inquiry processing system using the National Council for Prescription Drug Programs' current standards to communicate information to pharmacies submitting claim inquiries;

2. Fully disclose to insurers, self-funded employers, unions or other PBM clients the existence of the respective aggregate prescription drug discounts, rebates received from drug manufacturers and pharmacy audit recoupments;

3. Provide the Attorney General, insurers, self-funded employer plans and unions unrestricted audit rights of and access to the respective PBM pharmaceutical manufacturer and provider contracts, plan utilization data, plan pricing data, pharmacy utilization data and pharmacy pricing data;

4. Maintain, for no less than three (3) years, documentation of all network development activities including but not limited to contract negotiations and any denials to providers to join networks. This documentation shall be made available to the Attorney General upon request; and

5. Report to the Attorney General, on a quarterly basis for each health insurer payor, on the following information:

- a. the aggregate amount of rebates received by the PBM,
- b. the aggregate amount of rebates distributed to the appropriate health insurer payor,
- c. the aggregate amount of rebates passed on to the enrollees of each health insurer payor at the point of sale that reduced the applicable deductible, copayment, coinsure or other cost sharing amount of the enrollee,
- d. the individual and aggregate amount paid by the health insurer payor to the PBM for pharmacy services itemized by pharmacy, drug product and service provided, and
- e. the individual and aggregate amount a PBM paid a provider for pharmacy services itemized by pharmacy, drug product and service provided.

E. Nothing in the Patient's Right to Pharmacy Choice Act shall prohibit the Attorney General from requesting and obtaining detailed data, including raw data, in response to the information provided by a PBM in the quarterly reports required by this section. The Attorney General may alter the frequency of the reports required by this section at his or her sole discretion.

F. The Attorney General may promulgate rules to implement the provisions of the Patient's Right to Pharmacy Choice Act, the Pharmacy Audit Integrity Act, and Sections 357 through 360 of Title 59 of the Oklahoma Statutes.

Added by Laws 2019, c. 426, § 5, eff. Nov. 1, 2019. Amended by Laws 2022, c. 38, § 2, emerg. eff. April 21, 2022; Laws 2023, c. 293, § 1, eff. Nov. 1, 2023; Laws 2024, c. 306, § 2, emerg. eff. May 15, 2024.

§36-6963. Health insurer to monitor activities and ensure compliance.

A. A health insurer shall be responsible for monitoring all activities carried out by, or on behalf of, the health insurer under the Patient's Right to Pharmacy Choice Act, and for ensuring that all requirements of this act are met.

B. Whenever a health insurer contracts with another person to perform activities required under this act, the health insurer shall be responsible for monitoring the activities of that person with

whom the health insurer contracts and for ensuring that the requirements of this act are met.

C. An individual may be notified at the point of sale when the cash price for the purchase of a prescription drug is less than the individual's copayment or coinsurance price for the purchase of the same prescription drug.

D. A health insurer or pharmacy benefits manager (PBM) shall not restrict an individual's choice of in-network provider for prescription drugs.

E. An individual's choice of in-network provider may include a retail pharmacy or a mail-order pharmacy. A health insurer or PBM shall not restrict such choice. Such health insurer or PBM shall not require or incentivize using any discounts in cost-sharing or a reduction in copay or the number of copays to individuals to receive prescription drugs from an individual's choice of in-network pharmacy.

F. A health insurer, pharmacy or PBM shall adhere to all Oklahoma laws, statutes and rules when mailing, shipping and/or causing to be mailed or shipped prescription drugs into the State of Oklahoma.

Added by Laws 2019, c. 426, § 6, eff. Nov. 1, 2019.

§36-6964. Formulary to identify drugs that offer greatest value.

A. A health insurer's pharmacy and therapeutics committee (P&T committee) shall establish a formulary, which shall be a list of prescription drugs, both generic and brand name, used by practitioners to identify drugs that offer the greatest overall value.

B. A health insurer shall prohibit conflicts of interest for members of the P&T committee.

1. A person may not serve on a P&T committee if the person is currently employed or was employed within the preceding year by a pharmaceutical manufacturer, developer, labeler, wholesaler or distributor.

2. A health insurer shall require any member of the P&T committee to disclose any compensation or funding from a pharmaceutical manufacturer, developer, labeler, wholesaler or distributor. Such P&T committee member shall be recused from voting on any product manufactured or sold by such pharmaceutical manufacturer, developer, labeler, wholesaler or distributor.

Added by Laws 2019, c. 426, § 7, eff. Nov. 1, 2019.

§36-6965. Power and authority to investigate, examine, and enforce.

A. The Attorney General shall have power and authority to examine and investigate the affairs of every pharmacy benefits manager (PBM) engaged in pharmacy benefits management in this state in order to determine whether such entity is in compliance with the

Patient's Right to Pharmacy Choice Act, the Pharmacy Audit Integrity Act, and Sections 357 through 360 of Title 59 of the Oklahoma Statutes.

B. The Attorney General shall have the power and authority to subpoena witnesses and records, whether prior to or during an investigation or prosecution of a complaint, from any relevant entity or persons to ensure compliance with the Patient's Right to Pharmacy Choice Act, the Pharmacy Audit Integrity Act, and Sections 357 through 360 of Title 59 of the Oklahoma Statutes.

C. All PBM files and records shall be subject to examination by the Attorney General or by duly appointed designees. The Attorney General, authorized employees and examiners shall have access to any of a PBM's files and records that may relate to a particular complaint under investigation or to an inquiry or examination by the Attorney General.

D. Every officer, director, employee or agent of the PBM, upon receipt of any inquiry from the Attorney General, shall, within twenty (20) days from the date the inquiry is sent, furnish the Attorney General with an adequate response to the inquiry.

E. When making an examination under this section, the Attorney General may retain subject matter experts, attorneys, appraisers, independent actuaries, independent certified public accountants or an accounting firm or individual holding a permit to practice public accounting, certified financial examiners or other professionals and specialists as examiners, the cost of which shall be borne by the PBM that is the subject of the examination.

F. 1. Protected health information (PHI) held by a PBM shall be provided at the request of the Attorney General for the purpose of conducting investigations into potential violations of state laws and regulations related to the PBM. Disclosure of protected health information shall be limited to the extent necessary for the investigation and enforcement of state law.

2. All disclosures of protected health information shall be made in compliance with all applicable federal and state privacy laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and other relevant laws protecting the privacy and confidentiality of health information.

3. Any protected health information obtained for an investigation shall be handled and maintained per applicable federal and state privacy laws and regulations, including HIPAA.

4. Unauthorized disclosure of protected health information obtained during an investigation is strictly prohibited and subject to legal penalties.

G. 1. If the Attorney General, after notice and opportunity for hearing, finds that any PBM operating within this state has not fully cooperated with an investigation or inquiry conducted by the Attorney General related to compliance with the Patient's Right to

Pharmacy Choice Act, the Pharmacy Audit Integrity Act, and Sections 357 through 360 of Title 59 of the Oklahoma Statutes, the Attorney General may instruct the Insurance Commissioner that the PBM be censured or his or her license be suspended or revoked. If the Attorney General makes such instruction, the Commissioner shall enforce the instructed action within thirty (30) days.

2. In addition to or in lieu of any censure, suspension, or revocation by the Commissioner, the Attorney General may levy a civil or administrative fine not less than One Hundred Dollars (\$100.00) and not greater than Ten Thousand Dollars (\$10,000.00) for each violation of this subsection and assess any other penalty or remedy authorized by this act. For purposes of this section, each day a PBM fails to comply with an investigation or inquiry may be considered a separate violation.

Added by Laws 2019, c. 426, § 8, eff. Nov. 1, 2019. Amended by Laws 2021, c. 472, § 9, emerg. eff. May 11, 2021; Laws 2023, c. 293, § 2, eff. Nov. 1, 2023; Laws 2024, c. 306, § 3, emerg. eff. May 15, 2024.

§36-6966. Repealed by Laws 2024, c. 306, § 7, emerg. eff. May 15, 2024.

§36-6966.1. Violations - Penalties - Hearings.

A. The Insurance Commissioner may censure, suspend, revoke, or refuse to issue or renew a license of or levy a civil penalty against any person licensed under the insurance laws of this state for any violation of the Patient's Right to Pharmacy Choice Act, Section 6958 et seq. of this title.

B. 1. If the Attorney General finds, after notice and opportunity for hearing, that a pharmacy benefits manager (PBM) violated one or more provisions of the Patient's Right to Pharmacy Choice Act, the Pharmacy Audit Integrity Act or the provisions of Sections 357 through 360 of Title 59 of the Oklahoma Statutes, the Attorney General may instruct the Insurance Commissioner that the PBM be censured or his or her license be suspended or revoked. If the Attorney General makes such instruction, the Commissioner shall enforce such action within thirty (30) days.

2. In addition to or in lieu of any censure or suspension or revocation of a license by the Commissioner, the Attorney General may levy a civil or administrative fine not less than One Hundred Dollars (\$100.00) and not greater than Ten Thousand Dollars (\$10,000.00) for each violation of the provisions of the Patient's Right to Pharmacy Choice Act, the Pharmacy Audit Integrity Act or the provisions of Sections 357 through 360 of Title 59 of the Oklahoma Statutes.

3. The Attorney General may order restitution for economic loss suffered by pharmacies or patients for violations of the Patient's Right to Pharmacy Choice Act, the Pharmacy Audit Integrity Act, or

the provisions of Sections 357 through 360 of Title 59 of the Oklahoma Statutes.

C. Notwithstanding whether the license of a PBM has been issued, suspended, revoked, surrendered or lapsed by operation of law, the Attorney General is hereby authorized to enforce the provisions of the Patient's Right to Pharmacy Choice Act and impose any penalty or remedy authorized under the act against a PBM under investigation for or charged with a violation of the Patient's Right to Pharmacy Choice Act, the Pharmacy Audit Integrity Act, the provisions of Sections 357 through 360 of Title 59 of the Oklahoma Statutes or any provision of the insurance laws of this state.

D. Each day that a PBM conducts business in this state without a license from the Insurance Department shall be deemed a violation of the Patient's Right to Pharmacy Choice Act.

E. 1. All hearings conducted by the Office of the Attorney General pursuant to this section shall be public and held in accordance with the Administrative Procedures Act.

2. Hearings shall be held at the Office of the Attorney General or any other place the Attorney General may deem convenient.

3. The Attorney General, upon written request from a PBM affected by the hearing, shall cause a full stenographic record of the proceedings to be made by a competent court reporter. This record shall be at the expense of the PBM.

4. The ordinary fees and costs of the hearing examiner appointed pursuant to Section 319 of this title may be assessed by the hearing examiner against the respondent unless the respondent is the prevailing party.

F. Any PBM whose license has been censured, suspended, revoked or denied renewal or who has had a fine levied against him or her shall have the right of appeal from the final order of the Attorney General, pursuant to Section 318 et seq. of Title 75 of the Oklahoma Statutes.

G. If the Attorney General determines, based upon an investigation of complaints, that a PBM has engaged in violations of the provisions of the Patient's Right to Pharmacy Choice Act, the Pharmacy Audit Integrity Act, and Sections 357 through 360 of Title 59 of the Oklahoma Statutes with such frequency as to indicate a general business practice, and that the PBM should be subjected to closer supervision with respect to those practices, the Attorney General may require the PBM to file a report at any periodic interval the Attorney General deems necessary.

H. 1. The Attorney General shall have the authority to collect all fines, penalties, restitution, and interest thereon pursuant to the provisions of the Patient's Right to Pharmacy Choice Act, the Pharmacy Audit Integrity Act, and the provisions of Sections 357 through 360 of Title 59 of the Oklahoma Statutes, or any other charge, cause of action, prelitigation settlement, or other

settlement that requires the recovery of money as a result of violations of the Patient's Right to Pharmacy Choice Act. Funds collected by the Attorney General pursuant to the Patient's Right to Pharmacy Choice Act, the Pharmacy Audit Integrity Act, and Sections 357 through 360 of Title 59 of the Oklahoma Statutes shall be deposited into the Attorney General's Pharmacy Benefits Manager Enforcement Revolving Fund created in Section 5 of this act.

2. Costs of investigation, litigation, attorney fees, and other expenses incurred shall be retained by the Office of the Attorney General. Remaining funds shall be distributed to pharmacists, patients, or other injured parties as determined by the Attorney General.

3. The Attorney General shall promulgate rules for the distribution of funds pursuant to this subsection. Added by Laws 2022, c. 38, § 3, emerg. eff. April 21, 2022. Amended by Laws 2023, c. 293, § 3, eff. Nov. 1, 2023; Laws 2024, c. 306, § 4, emerg. eff. May 15, 2024.

§36-6966.2. Attorney General's Pharmacy Benefits Manager Enforcement Revolving Fund.

There is hereby created in the State Treasury a revolving fund for the Office of the Attorney General, to be designated the "Attorney General's Pharmacy Benefits Manager Enforcement Revolving Fund". The fund shall be a continuing fund, not subject to fiscal year limitations, and shall consist of any monies collected by the Attorney General and designated to the fund by law, including those levied for activities related to enforcement of the Patient's Right to Pharmacy Choice Act, the Pharmacy Audit Integrity Act, and the provisions of Sections 357 through 360 of Title 59 of the Oklahoma Statutes. All monies accruing to the credit of the fund are hereby appropriated and may be budgeted and expended by the Attorney General for the purposes provided in this section. Expenditures from the fund shall be made upon warrants issued by the State Treasurer against claims filed as prescribed by law with the Director of the Office of Management and Enterprise Services for approval and payment.

Added by Laws 2024, c. 306, § 5, emerg. eff. May 15, 2024.

§36-6967. Confidentiality and privilege of information.

A. Documents, evidence, materials, records, reports, complaints or other information in the possession or control of the Office of the Attorney General or Insurance Department that are obtained by, created by or disclosed to the Office of the Attorney General or Insurance Commissioner or any other person in the course of an evaluation, examination, investigation or review made pursuant to the provisions of the Patient's Right to Pharmacy Choice Act, the Pharmacy Audit Integrity Act or Sections 357 through 360 of Title 59

of the Oklahoma Statutes, except as provided in subsection C of this section, shall be confidential by law and privileged, shall not be subject to open records request, shall not be subject to subpoena and shall not be subject to discovery or admissible in evidence in any private civil action if obtained from the Attorney General, Insurance Commissioner, or any employees or representatives of the Attorney General or Insurance Commissioner.

B. Nothing in this section shall prevent the disclosure of a final order issued against a pharmacy benefits manager by the Office of the Attorney General or Insurance Commissioner. Such orders shall be open records.

C. Nothing in this section shall prevent the Attorney General from making public, in the form of an examination report, any findings from an examination pursuant to Section 6965 of this title. It shall be the Attorney General's sole discretion to determine whether it is in the public's interest to publish these findings. Only the final examination report shall be made public. Any documents, evidence, materials, records, reports, complaints, or other information in possession or control of the Attorney General obtained through the examination shall be confidential by law and privileged, shall not be subject to the Oklahoma Open Records Act, shall not be subject to subpoena, and shall not be subject to discovery or admissible evidence in any private civil action if obtained from the Attorney General.

D. In the course of any hearing made pursuant to the provisions of the Patient's Right to Pharmacy Choice Act, the Pharmacy Audit Integrity Act or Sections 357 through 360 of Title 59 of the Oklahoma Statutes, nothing in this section shall be construed to prevent the Insurance Commissioner or any employees or representatives of the Insurance Commissioner from presenting admissible documents, evidence, materials, records, reports or complaints to the adjudicating authority.

Added by Laws 2019, c. 426, § 10, eff. Nov. 1, 2019. Amended by Laws 2021, c. 472, § 11, emerg. eff. May 11, 2021; Laws 2024, c. 306, § 6, emerg. eff. May 15, 2024.

§36-6968. Severability.

If any one or more provision, section, subsection, sentence, clause, phrase or word of this act or the application hereof to any person or circumstance is found to be unconstitutional, the same is hereby declared to be severable and the balance of this act shall remain effective notwithstanding such unconstitutionality. The Legislature hereby declares that it would have passed this act, and each provision, section, subsection, sentence, clause, phrase or word thereof, irrespective of the fact that any one or more provision, section, subsection, sentence, clause, phrase, or word be declared unconstitutional.

Added by Laws 2019, c. 426, § 11, eff. Nov. 1, 2019.

§36-6969. Restrictions on health benefit plans and pharmacy benefit managers – White bagged drugs.

A. As used in this section:

1. "Health benefit plan" means a health benefit plan as defined pursuant to Section 6060.4 in Title 36 of the Oklahoma Statutes;

2. "Pharmacy benefits manager" means a person that performs pharmacy benefits management and any other person acting for such person under a contractual or employment relationship in the performance of pharmacy benefits management for a managed-care company, not-for-profit hospital, medical services organization, insurance company, third-party payor, or a health program administered by a state agency; and

3. "White bagged drugs" means the distribution of physician administered medication from a pharmacy, typically a specialty pharmacy, to the physician's office, hospital, or clinic for administration.

B. All health benefit plans and pharmacy benefits managers in this state shall not refuse to authorize, approve, or pay a participating provider for providing covered physician-administered drugs to covered persons.

C. All white bagged drugs distributed in this state shall meet supply chain security controls set forth by the federal Drug Supply Chain Security Act as amended.

D. A health benefit plan or a pharmacy benefits manager of a plan shall not require a covered patient to self-administer an injectable drug against a health care provider's recommendation in accordance with the manufacturer's approved guidelines.

E. Health benefit plans shall not require a covered patient to pay additional fees for white bagged drugs beyond cost-sharing obligations as outlined in the individual's plan.

F. Providers and health care facilities shall be permitted to dispense and administer a covered physician-administered drug based on a patient's best interest, provided that the health care facility or provider that administers the drug shall agree to the terms and conditions of network participation and accept, as payment in full, reimbursement for the drug at the health insurer's negotiated contracted rate. The health care facility or provider is prohibited from billing or collecting from the patient any amount in excess of or in addition to the patient's cost sharing obligations as outlined in the individual's plan.

G. Any payor in violation of this act shall be fined a minimum of Five Thousand Dollars (\$5,000.00) per violation, but not more than Ten Thousand Dollars (\$10,000.00) per violation. Fines related to this section shall not be used when calculating payors, plans, or

members loss ratios and losses incurred pursuant to this subsection shall not be passed on to the consumer in future rate increases. Added by Laws 2024, c. 185, § 1, emerg. eff. April 29, 2024.

§36-6971. Electronic provider directories for health benefit plans.

A. As used in this section:

1. "Health benefit plan" means a plan as defined pursuant to Section 6060.4 of Title 36 of the Oklahoma Statutes;
2. "Health care facility" means a facility as defined pursuant to Section 1-725.2 of Title 63 of the Oklahoma Statutes;
3. "Health care professional" means a professional as defined pursuant to Section 6802 of Title 36 of the Oklahoma Statutes;
4. "Hospital" means a hospital as defined pursuant to Section 1-701 of Title 63 of the Oklahoma Statutes; and
5. "Provider" means a health care provider as defined pursuant to Section 6571 of Title 36 of the Oklahoma Statutes.

B. Any insurer of a health benefit plan that is offered, issued, or renewed in this state on or after the effective date of this act shall publish an electronic provider directory for each of its network plans, to be updated every sixty (60) days. The insurer shall make clear the provider directory that applies to each network plan as marketed and issued in this state. The electronic directory shall be published on an easily accessible website in a standardized, downloadable, and searchable format. The electronic directory shall include the following information:

1. For health care professionals:
 - a. name,
 - b. contact information, including a website address, physical address, and phone number, and
 - c. specialty, if applicable;
2. For hospitals:
 - a. hospital name,
 - b. hospital type, including, but not limited to, acute, rehabilitation, children's, or cancer,
 - c. participating hospital location,
 - d. hospital accreditation status,
 - e. customer service telephone number, and
 - f. website address; and
3. For health care facilities other than hospitals:
 - a. facility name,
 - b. facility type,
 - c. types of services performed,
 - d. participating facility location or locations,
 - e. customer service telephone number, and
 - f. website address.

C. Any insurer of a health benefit plan that publishes a provider directory pursuant to this section shall ensure that the

general public is able to view all of the current providers for a network plan, through a clearly identifiable hyperlink or website tab, without requiring any person to create or sign into an account or submit a policy or contract number.

D. For each network plan published, an insurer of a health benefit plan shall include in plain language the following information:

1. A description of the criteria used to build its provider network; and

2. If applicable:

- a. a description of the criteria used to tier providers,
- b. how the plan designates the different provider tiers or levels, including, but not limited to, by name, symbols, or grouping, in the network and for each specific provider in the network, which tier each is placed for an insured or a prospective insured to be able to identify the provider tier, and
- c. a notice that authorization or referral may be required to access some providers.

E. 1. Provider directories, whether in electronic or, if offered, print format, shall be accessible to individuals with disabilities and individuals with limited English proficiency as defined in 45 C.F.R. Sections 92.201 and 155.205.

2. The plan shall include a disclosure in any print directory issued under this subsection that the information in the directory is accurate as of the date of printing and that an insured or prospective insured should consult the electronic provider directory on the website of the plan or call the listed customer service telephone number to obtain current provider directory information.

F. 1. The health benefit plan shall include in both its online and print directories, if offered, a clearly identifiable telephone number, email address, or link to a webpage which an insured or the general public may use to report to the plan inaccurate information listed in the provider directory. Whenever a plan receives a report, it shall promptly investigate the report and, not later than two (2) days following the receipt of such report, either verify the accuracy of the information or update the information.

2. A plan shall take appropriate steps to ensure the accuracy of the information concerning each provider listed in the provider directory. The plan shall contact providers as necessary to ensure that the information provided in the directory is up to date.

3. The plan shall, at least annually, audit its provider directories for accuracy. The audit should be focused on the top four utilized specialties to include at least one specialty related to mental health. Alternatively, plans may audit based on a reasonable sample size of providers, as long as the sample size includes behavioral health providers. The plan shall retain

documentation of any audit conducted under this paragraph to be made available to the Insurance Commissioner. Based on the results of a given audit, the plan shall verify and attest to the accuracy of the information or update the information.

G. An insurer of a health benefit plan shall, by certified mail, return receipt requested, or by electronic mail, read receipt requested, notify any provider of its removal from the network if the provider has not submitted claims to the plan or otherwise communicated intent to continue participation in the plan network within a twelve-month period. If the provisions of the contract entered between the plan and the provider provides notice terms, the notice shall be provided in accordance with such terms. If the plan does not receive a response from the provider within thirty (30) days of such notification, the plan shall remove the provider from the network.

H. In accordance with any timeframes and requirements that may be established by the Commissioner, an insurer of a health benefit plan shall report to the Commissioner the following:

1. The number of reports received pursuant to subsection F of this section, the timeliness of the response from the plan, and the corrective action or actions taken; and

2. All auditing reports conducted by the plan pursuant to subsection F of this section.

I. If an insured reasonably relies upon materially inaccurate information contained in a provider directory of a plan, the Commissioner may require the plan to provide coverage for all covered health care services provided to the insured and to reimburse the insured for any amount that he or she would have to pay if the services would have been delivered by an in-network provider under the network plan. Provided, the Commissioner shall take into consideration that health benefit plan insurers are relying on health care providers to report changes to their information prior to requiring any reimbursement to an insured. In the event that the Commissioner finds that the provider has not provided updated information for the network directory of the insurer of a health benefit plan, the Commissioner may require that the provider be reimbursed at the assignment of benefits rate for the service if it were conducted in-network. Prior to requiring reimbursement under this subsection, the Commissioner shall conclude that the services received by the plan were covered services under the insured's network plan. If the services satisfy requirements of this subsection, a plan shall not deny reimbursement to an insured based on the provider of the services being out-of-network.

J. The Commissioner may promulgate rules to effectuate the provisions of this section.

Added by Laws 2023, c. 191, § 1, eff. Nov. 1, 2023.

§36-6972. Definitions.

As used in this act:

1. "Contractual discount" means a reduction from a provider's usual and customary rate for covered services and materials required under a prepaid vision plan agreement with a provider;

2. "Covered materials" means materials for which reimbursement from the insurer, vision plan, or vision care discount plan is provided to a vision care provider by an enrollee's plan contract, or for which a reimbursement would be available but for the application of the enrollee's contractual limitations of deductibles, copayments, or coinsurance;

3. "Covered services" means services eligible for reimbursement from the insurer or vision plan to a provider, or services that would be eligible for reimbursement but for the application of the enrollee's contractual plan limitations of deductibles, copayments, or coinsurance, regardless of how the benefits are listed in the explanation of benefits provided in the vision plan of the enrollee;

4. "Enrollee" means any individual enrolled in a health care plan, vision plan, or vision care discount plan provided by a group, employer, or other entity that purchases or supplies coverage for a vision plan;

5. "Extrapolation" means a mathematical process or technique used by a vision plan in the process of auditing a vision care provider to estimate audit results for a larger batch of group claims not reviewed in the audit by the plan;

6. "Health benefit plan" means a health benefit plan as defined pursuant to Section 6060.4 of Title 36 of the Oklahoma Statutes;

7. "Materials" means ophthalmic devices including but not limited to lenses, devices containing lenses, artificial intraocular lenses, ophthalmic frames and other lens mounting apparatus, prisms, lens treatments and coatings, contact lenses, and prosthetic devices to correct, relieve, or treat defects or abnormal conditions of the human eye or its adnexa, or any material allowed to be utilized by the Board of Examiners in Optometry and optometry's scope of practice as provided by law;

8. "Net equity" means the excess of total assets over total liabilities, excluding liabilities which have been subordinated in a manner acceptable to the Insurance Commissioner;

9. "Prepaid vision plan" means any contractual agreement whereby any prepaid vision plan organization undertakes to provide full payment or a discount of vision services directly, to arrange for prepaid vision services, or to pay or make reimbursement for any vision service not provided for by other insurance;

10. "Prepaid vision plan organization" means any person who, or organization or entity that, undertakes to conduct one or more prepaid vision plans providing only vision services;

11. "Services" means the professional work performed by a vision care provider;

12. "Subcontractor" means any company, group, or third-party entity including agents, servants, partially or wholly owned subsidiaries, and controlled organizations contracted by the insurer, vision plan, or vision care discount plan to supply services or materials for a vision care provider or enrollee to fulfill the benefit plan of an insurer, vision plan, or vision care discount plan;

13. "Tangible net equity" means net equity reduced by the value assigned to intangible assets including, but not limited to, goodwill, going concern value, organizational expenses, start-up costs, long-term prepayments of deferred charges, nonreturnable deposits, and obligations of officers, directors, owners, or affiliates, except short-term obligations of affiliates for goods or services arising in the normal course of business that are payable on the same term as equivalent transactions with nonaffiliates and that are not past due;

14. "Uncovered expense" means the cost of health care services that are the obligation of a prepaid vision plan organization for which:

- a. an enrollee may be liable in the event of the insolvency of the organization, and
- b. alternative arrangements acceptable to the Commissioner have not been made to cover the costs; and

15. "Vision care provider" or "provider" means a licensed doctor of optometry or a licensed medical or osteopathic doctor practicing under the authority of the applicable provisions of Title 59 of the Oklahoma Statutes.

Added by Laws 2024, c. 360, § 1, emerg. eff. May 30, 2024.

§36-6973. Reimbursements – Charges – Pricing – Incentivization.

A. No agreement between an insurer or prepaid vision plan and a vision care provider may require that a provider provide services or materials at a fee limited or set by the insurer or prepaid vision plan, unless the services or materials are reimbursed as covered services or covered materials under the contract.

B. A provider shall not charge more for services and materials that are not covered services or materials to an enrollee of a prepaid vision plan or insurer than his or her usual and customary rate for those services and materials.

C. Reimbursements paid by an insurer or prepaid vision plan for covered services and covered materials, regardless of the supplier or optical lab used to obtain materials, shall be at the usual, customary, and reasonable rate and made available to the vision care provider prior to the provider accepting a contract from the insurer

or prepaid vision plan. An insurer or prepaid vision plan shall not provide nominal reimbursement or advertise services and materials to be covered with additional copay or coinsurance in order to claim that services and materials are covered services and materials if the health benefit plan or prepaid vision plan does not reimburse for the services or materials.

D. Prepaid vision plans shall not in any manner impact the pricing of noncovered services or materials.

E. Prepaid vision plans shall provide standard reimbursements for all lenses with the same design, quality, and composition. The period of time prescribed by a contract between any prepaid vision plan and a provider for the plan to recover any reimbursement amount from a provider shall be the same period of time allowed or required for any provider to recover any reimbursement amount from a prepaid vision plan.

F. A prepaid vision plan shall not use extrapolation to complete an audit of a vision care provider. Any additional payment due to a provider or any refund to a prepaid vision plan shall be based on actual overpayment or underpayment and shall not be based on extrapolation.

G. A prepaid vision plan shall not incentivize patients to receive vision care services at an entity owned wholly or in part by the plan or subsidiaries of the plan. Any entity providing vision care services shall provide notice to patients that an entity is owned wholly or in part by the plan or subsidiaries of the plan.

H. No person or entity shall sell, solicit, or negotiate any prepaid vision plan to an enrollee in this state without an approved certificate of authority under Section 7 of this act.

Added by Laws 2024, c. 360, § 2, emerg. eff. May 30, 2024.

§36-6974. Credentials – Reimbursement and requirements for physicians and optometrists – Subcontracts.

A. 1. No agreement between an insurer or a prepaid vision plan and a vision care provider shall require that a provider participate with or be credentialed by any specific prepaid vision plan as a condition for participation in the health care network of the insurer to provide covered services to its enrollees.

2. In the event that a vision care provider is credentialed by an insurer or vision care plan organization, no insurer or vision care plan organization shall construe re-credentialing as re-contracting with a vision care provider. All contracts shall be distinct and separate documents from any credentialing materials.

B. Any insurer issuing or renewing a health benefit plan or prepaid vision plan which provides coverage for services rendered by a duly licensed physician or osteopath that are within the scope of practice of a duly licensed optometrist shall provide the same

reimbursement for services to optometrists as allowed for those services rendered by physicians or osteopaths.

C. No insurer or prepaid vision plan organization shall require an optometrist to meet terms and conditions that are not required of a physician or osteopath as a condition for participation in its provider network for the provision of services that are within the scope of practice of an optometrist.

D. If a vision care provider enters into any subcontract agreement with another provider to provide his or her licensed health care services to the enrollee, dependent of the enrollee, or an enrollee of a managed care plan where the subcontracted provider will bill the managed care plan or enrollee directly for the subcontracted services, the subcontract agreement shall meet all requirements of this act.

Added by Laws 2024, c. 360, § 3, emerg. eff. May 30, 2024.

§36-6975. Agreement between provider and insurer or organization – Changes to agreement.

A. An insurer or prepaid vision plan organization shall not change or alter an agreement entered into with a vision care provider unless the insurer or organization:

1. Provides notice of any proposed change to the provider through a certified letter or an electronic communication requiring an electronic signature proving receipt detailing proposed changes to the vision care provider. A face-to-face or virtual meeting shall be conducted if requested by the provider. If the changes in the contract are not agreed to by the vision care provider within ninety (90) days of the date of the provided notice, the agreement shall terminate; and

2. Supplies the vision care provider with an explanation of benefits and an explanation of payment for services and materials rendered by the provider upon request, regardless of the provider's network status with the vision plan.

B. 1. A new agreement is required to be established and agreed upon after three or more material changes are made to an existing agreement from an insurer, vision plan, or vision care discount plan.

2. Any amendment to a proposed contract that is being reviewed by a provider prior to its execution and any amendment to an existing contract with a service provider shall be underlined to clearly indicate the contract modification.

Added by Laws 2024, c. 360, § 4, emerg. eff. May 30, 2024.

§36-6976. Restrictions on provider choice of sources and suppliers – Reimbursement.

No agreement between an insurer or prepaid vision plan and a vision care provider shall restrict or limit, either directly or

indirectly, the provider's choice of sources and suppliers of services or materials or use of optical labs provided by the vision care provider to an enrollee. Vision care providers shall not receive reduced reimbursement for using labs and suppliers that the provider chooses to best serve patient outcomes.
Added by Laws 2024, c. 360, § 5, emerg. eff. May 30, 2024.

§36-6977. Certificate of authority to operate as prepaid vision plan organization.

A. No person, organization, or entity, unless authorized pursuant to an approved certificate of authority under Section 7 of this act, shall establish or operate a prepaid vision plan organization in this state or sell, offer to sell, solicit offers to purchase, or receive advance or periodic consideration in conjunction with a prepaid vision plan without obtaining and maintaining a certificate of authority.

B. On or before February 1, 2025, every prepaid vision plan organization operating in this state shall submit an application for a certificate of authority to the Insurance Commissioner. Each applicant may continue to operate as an organization until the Commissioner acts upon the application.

C. An application for a certificate of authority to operate as a prepaid vision plan organization shall be electronically filed with the Insurance Commissioner in the form and manner prescribed by the Commissioner, along with any transaction or other applicable fees. The application shall be verified by an officer or authorized representative of the applicant and shall set forth or be accompanied by:

1. A copy of any documents of organization of the applicant such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, with all amendments to the documents;

2. A copy of any bylaws, rules, regulations, or similar documents regulating the conduct of the internal affairs of the applicant;

3. A list of the names, addresses, and official positions of the persons who are responsible for the conduct of the business affairs of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, and the principal officers, in the case of a corporation, or the partners or members in the case of a partnership or association;

4. A copy of the form of any contract made or to be made between any providers of vision services or persons listed in paragraph 3 of this subsection and the applicant;

5. A statement generally describing the prepaid vision plan organization, the facilities, personnel of the organization, and prepaid vision plans offered by the organization;

6. A copy of the form of individual or group coverage or a copy of any form of evidence of coverage to be issued to enrollees;

7. Financial statements showing assets, liabilities, and sources of financial support of the applicant. If the financial affairs of the applicant are audited by independent certified public accountants, a copy of the most recent regular certified financial statement for the applicant shall satisfy the requirement of this paragraph, unless the Commissioner determines that additional or more recent financial information is required;

8. A description of the proposed method of marketing the prepaid vision plan, a financial prospectus which includes a three-year projection of the initial operating results anticipated, and a statement as to the sources of working capital available for the operation of the prepaid vision plan and any other source of funding;

9. A power of attorney, duly executed by the applicant if not domiciled in this state, appointing the Commissioner as the true and lawful representative for service of process for the applicant in this state upon whom all lawful process in any legal action or proceeding against the prepaid vision plan organization on a cause of action arising in this state may be served;

10. A fee of One Hundred Dollars (\$100.00) for issuance of a certificate of authority; and

11. Any other information as the Commissioner may require.

D. Within ten (10) days following any modification of information previously furnished as required by subsection C of this section, a prepaid vision plan organization shall file a notice of the modification with the Commissioner, in the form and manner prescribed by the Commissioner, along with any applicable fees.

E. Any service of legal process against a prepaid vision plan organization served upon the Commissioner shall comply with all requirements set forth pursuant to Section 622 of Title 36 of the Oklahoma Statutes for legal processes against a foreign or alien insurer.

Added by Laws 2024, c. 360, § 6, emerg. eff. May 30, 2024.

§36-6978. Conditions for issuance of certificate of authority.

A. Issuance of a certificate of authority for a prepaid vision plan organization shall be granted by the Insurance Commissioner if the Commissioner is satisfied that the following conditions are met:

1. The requirements of Section 6 of this act have been fulfilled;

2. The persons, organization, or entity responsible for conducting the business affairs of the prepaid vision plan

organization are competent, trustworthy, and professionally capable of providing or arranging for the provision of services offered;

3. The prepaid vision plan organization constitutes an appropriate mechanism to achieve an effective prepaid vision plan;

4. The prepaid vision plan organization has filed with the Commissioner a fidelity bond that is in its own name on its officers and employees in an amount not less than Fifty Thousand Dollars (\$50,000.00) and is subject to the approval of the Commissioner;

5. The financial structure of the prepaid vision plan organization may reasonably be expected to meet obligations for payment of services for enrollees and prospective enrollees. In making this determination, the Commissioner may consider:

- a. the financial soundness of the arrangements made pursuant to the provisions of the prepaid vision plan for services and the schedule of charges used,
- b. any agreement with an insurer, hospital, medical service corporation, or any other organization for ensuring the payment of prepaid vision services,
- c. provisions in the plan for automatic coverage of vision services if the prepaid plan is discontinued, and
- d. the sufficiency of the agreement for prepaid vision services with providers of vision services; and

6. The Commissioner has not made a determination that the prepaid vision plan organization is incompetent, untrustworthy, or financially irresponsible, and the organization has not had any insurance license denied for cause by any state.

B. A certificate of authority shall expire at midnight on June 30 following the date of issuance or the most recent renewal date, and annually on June 30 thereafter. If the prepaid vision plan organization remains in compliance with the provisions of this act and pays a renewal fee of One Hundred Dollars (\$100.00), the certificate of authority may be renewed.

C. Every prepaid vision plan organization, upon receipt of any inquiry from the Insurance Commissioner, shall furnish the Commissioner with an adequate response to the inquiry within twenty (20) days from the receipt of inquiry.

Added by Laws 2024, c. 360, § 7, emerg. eff. May 30, 2024.

§36-6979. Tangible net equity requirements – Trust deposit.

A. 1. Except as approved in accordance with subsection B of this section, each prepaid vision plan organization shall at all times have and maintain tangible net equity equal to the greater of:

- a. Fifty Thousand Dollars (\$50,000.00), or
- b. two percent (2%) of the organization's annual gross premium income, up to a maximum of the required capital and surplus of an accident and health insurer.

2. A prepaid vision plan organization that has uncovered expenses in excess of Fifty Thousand Dollars (\$50,000.00), as reported on the most recent annual financial statement filed with the Insurance Commissioner, shall maintain tangible net equity equal to twenty-five percent (25%) of the uncovered expenses in excess of Fifty Thousand Dollars (\$50,000.00) in addition to the tangible net equity required by paragraph 1 of this subsection.

B. 1. Each prepaid vision plan organization shall deposit in trust with the Commissioner cash, securities eligible for the investment of capital funds under the Oklahoma Insurance Code, other measures deemed acceptable by the Commissioner, or any combination thereof in an amount equal to Twenty-five Thousand Dollars (\$25,000.00) plus twenty-five percent (25%) of the tangible net equity required in subsection A of this section; provided, however, that the deposit shall not be required to exceed One Hundred Thousand Dollars (\$100,000.00). Any securities deposited under this subsection shall be issued to the Commissioner and the prepaid vision plan organization and shall not be released by any company holding such security without the signatures of the Commissioner and the authorized prepaid vision plan organization's personnel.

2. The deposit shall be an admitted asset of the prepaid vision plan organization in the determination of tangible net equity.

3. All income from deposits shall be an asset of the prepaid vision plan organization. A prepaid vision plan organization may withdraw a deposit or any part thereof after making a substitute deposit of an equal amount and value. Any securities shall be approved by the Commissioner before being substituted.

4. The deposit shall be used to protect the interests of the members of the prepaid vision plan organization and to assure continuation of vision plan services to members of a prepaid vision plan organization that is in rehabilitation or conservation. If a prepaid vision plan organization is placed in receivership or liquidation, the deposit shall be an asset subject to the provisions of Article 19 of the Oklahoma Insurance Code pursuant to Section 1901 et seq. of Title 36 of the Oklahoma Statutes, provided the deposit shall not be subject to attachment by any creditors of the prepaid vision plan organization.

5. The deposit shall not apply to a prepaid vision plan organization that is funded by the United States government, this state, or a political subdivision thereof.

Added by Laws 2024, c. 360, § 8, emerg. eff. May 30, 2024.

§36-6980. Authority to increase requirements.

The Insurance Commissioner may increase the amounts required under this act for tangible net equity, capital maintained, fidelity bond, and deposit to any amount the Commissioner determines to be

appropriate if the Commissioner determines that such an increase is necessary to:

1. Assist the Commissioner in the performance of his or her regulatory duties;

2. Ensure the prepaid vision plan organization complies with the requirements of this act; or

3. Ensure the solvency of the prepaid vision plan organization. Added by Laws 2024, c. 360, § 9, emerg. eff. May 30, 2024.

§36-6981. Policy of coverage – Issuance to enrollees – Filing and approval – Requirements.

A. Every enrollee of a prepaid vision plan shall be issued a coverage policy by the prepaid vision plan organization. No policy for coverage or amendment to the policy shall be issued or delivered to any person in this state until a copy of the policy for coverage or amendment to the policy has been filed with and approved by the Insurance Commissioner.

B. A policy for coverage shall contain a statement of:

1. The prepaid vision services or other benefits to which the enrollee is entitled under the prepaid vision plan;

2. Any limitations of the services or benefits to which the enrollee is entitled under the prepaid vision plan;

3. Information as to how services may be obtained; and

4. The obligation of the enrollee for charges for the prepaid vision plan.

C. The Commissioner shall approve any policy of coverage if the requirements of this section are complied with and the prepaid vision plan, in the judgment of the Commissioner, is able to meet its financial obligations for the membership coverage. It shall be unlawful for a prepaid vision plan organization to issue a policy until it is approved by the Commissioner.

D. 1. If the Commissioner does not disapprove any policy within thirty (30) days after filing, the policy shall be deemed approved.

2. If the Commissioner disapproves a policy of membership coverage, the Commissioner shall notify the prepaid vision plan organization, specifying the reasons for disapproval. The Commissioner shall grant a hearing on any disapproval within thirty (30) days after a request in writing for a hearing is received by the Commissioner from the prepaid vision plan organization.

Added by Laws 2024, c. 360, § 10, emerg. eff. May 30, 2024.

§36-6982. Report of business activities – Annual filing.

A. On or before March 1 of each calendar year, every prepaid vision plan organization offering coverage in this state shall file with the Insurance Commissioner a report of the business activities of the organization for the preceding calendar year. The report

shall contain a notarized signature of at least two principal officers of the corporation or members of the entity.

B. A report submitted under this section shall be in the form and manner prescribed by the Commissioner and shall include:

1. A financial statement of the organization, including a copy of the balance sheet, receipts, and disbursements of the organization for the subject year certified by an independent certified public accountant. The Commissioner may accept a full report of the most recent examination of a foreign prepaid vision plan, certified to by the appropriate examining official of another state;

2. Any material changes in the information required to be provided pursuant to Section 6 of this act;

3. The number of persons who have enrolled in plans offered by the organization during the preceding year, the total number of enrollees of each plan as of the end of the year, and the number of enrollments terminated during the year;

4. The costs of all care provided and the number of enrollees who received care pursuant to the provisions of the prepaid vision plan; and

5. Any other information relating to the performance of the prepaid vision plan organization deemed necessary by the Commissioner.

Added by Laws 2024, c. 360, § 11, emerg. eff. May 30, 2024.

§36-6983. Certificate of authority – Suspension of revocation – Fines–Hearing.

A. The Insurance Commissioner may suspend or revoke any certificate of authority issued pursuant to this act if the Commissioner finds that the prepaid vision plan organization:

1. Is operating contrary to the basic organizational documents of the organization or in a manner contrary to that described in or reasonably inferred from any information submitted pursuant to Section 6 of this act;

2. Issues a coverage policy which does not comply with the requirements of Section 10 of this act;

3. Does not provide or arrange for basic vision services appropriate to a prepaid vision plan;

4. Can no longer be expected to meet the obligations to enrollees or prospective enrollees of the prepaid vision plan;

5. Uses fraudulent, coercive, or dishonest practices, or demonstrates incompetence, untrustworthiness, or financial irresponsibility in the conduct of business;

6. Fails to deal equitably with any providers or other persons or facilities which offer services covered within a contract or policy issued pursuant to this act; or

7. Fails to substantially comply with the insurance laws of this state or violates any regulation, rule, subpoena, or order of the Commissioner.

B. When the certificate of authority of a prepaid vision plan organization is suspended, the organization shall not accept, during the period of such suspension, any additional enrollments for coverage except newly acquired dependents of existing enrollees and shall not engage in any advertising or solicitation.

C. When the certificate of authority of a prepaid vision plan organization is revoked, the organization shall terminate operation of the organization in this state immediately and shall conduct no further business except as may be essential to the orderly conclusion of the business affairs of the organization. The Commissioner, by written order, may permit further operation of the organization as the Commissioner finds to be in the best interest of members of the organization.

D. In addition to or in lieu of any applicable suspension or revocation of a certificate of authority, the Commissioner may invoke a fine not to exceed One Thousand Dollars (\$1,000.00) for each violation. The payment of the fine may be enforced in the same manner as civil judgments may be enforced.

E. A prepaid vision plan organization which has had its certificate of authority denied, suspended, or revoked, or has suffered an adverse determination by the Commissioner shall be entitled to a hearing pursuant to the provisions of the Administrative Procedures Act under Section 250 et seq. of Title 75 of the Oklahoma Statutes.

Added by Laws 2024, c. 360, § 12, emerg. eff. May 30, 2024.

§36-6984. Advertising or sales materials required – Filing and approval.

A. 1. No advertising or sales material relating to a prepaid vision plan organization shall be issued or delivered to any person in this state until a copy of the material has been filed with and approved by the Insurance Commissioner.

2. Within thirty (30) days after the submission of advertising or material under this subsection, the Commissioner shall issue a determination approving or disapproving of the material.

3. Disapproval of the advertising or material shall be on the basis that, in whole or in part, the material is false, deceptive, or misleading. Written notification shall be issued to an organization that has materials disapproved pursuant to this subsection. Thereafter, the disapproved advertising material shall not be used.

4. Violation of the provisions of this subsection shall entitle the Commissioner in his or her discretion and without additional

cause to withdraw approval of any coverage policy with respect to which the advertising or sales material is used.

B. Advertisement and publication of material by a prepaid vision plan organization or anyone acting on behalf of the organization to inform enrollees or prospective enrollees of the plan as to the coverage offered by the plan and the operation of the organization shall not be a violation of any provisions of law relating to solicitation of customers or advertising by prepaid vision plan providers if the advertising or sales material:

1. Is approved prior to use by the Commissioner upon determination by the Commissioner that the material is not inaccurate, false, deceptive, or misleading;

2. Does not identify the providers of vision services nor describe their professional qualifications, except upon request of the enrollee or prospective enrollee;

3. Does not describe the professional experience or attainments of providers individually or as a group, or contain language that states, evaluates, or lauds the professional competence, skills, or reputations of the providers; and

4. Shall not cause any providers to violate any professional ethics or laws that prohibit the solicitation of patients.

Added by Laws 2024, c. 360, § 13, emerg. eff. May 30, 2024.

§36-6985. Examination of business affairs by Insurance Commissioner.

A. The Insurance Commissioner may conduct an examination of the business affairs of any prepaid vision plan organization as often as the Commissioner deems necessary for the protection of the interests of the people of this state.

B. Any receivership, rehabilitation, liquidation, or conservation of a prepaid vision plan organization shall be conducted pursuant to the provisions for the receivership, rehabilitation, liquidation, or conservation of an insurer provided for by Articles 18 and 19 of Title 36 of the Oklahoma Statutes.

C. The Commissioner shall promulgate any rules necessary to effectuate the provisions of this act.

Added by Laws 2024, c. 360, § 14, emerg. eff. May 30, 2024.

§36-6991. Prohibiting refusal of coverage for durable medical equipment.

A. As used in this section:

1. "Durable medical equipment" means equipment as defined pursuant to Section 375.2 of Title 59 of the Oklahoma Statutes;

2. "Health benefit plan" means a health benefit plan as defined pursuant to Section 6060.4 of Title 36 of the Oklahoma Statutes, but shall not include any health benefit plan offered by a contracted entity as defined in Section 4002.2 of Title 56 of the Oklahoma

Statutes that provides coverage to members of the state Medicaid program;

3. "Health care provider" means a provider as defined pursuant to Section 6571 of Title 36 of the Oklahoma Statutes;

4. "Health maintenance organization" or "HMO" means a health maintenance organization as defined pursuant to Section 6902 of Title 36 of the Oklahoma Statutes, but shall not include any health benefit plan offered by a contracted entity as defined in Section 4002.2 of Title 56 of the Oklahoma Statutes that provides coverage to members of the state Medicaid program; and

5. "Preferred provider organization" or "PPO" means a preferred provider organization as defined pursuant to Section 6054 of Title 36 of the Oklahoma Statutes.

B. No health benefit plan, HMO, PPO, or other provider network authorized to administer health care coverage in this state shall refuse coverage to an insured for durable medical equipment and supplies as prescribed by a health care provider, regardless of whether they are in-network or out-of-network, unless there is an Oklahoma-licensed in-network provider within a fifteen-mile radius of the patient's home address that can provide in-person evaluation for durable medical equipment, supplies, and related services.

C. If a health care provider deems it necessary that an insured receive covered durable medical equipment or supplies within twenty-four (24) hours, the insured shall not be subject to drop-shipped orders and may seek such equipment and supplies from any health care provider who can provide the necessary services and supplies within the requested time frame.

D. When an insured utilizes an out-of-network health care provider, as described in subsection B of this section, the out-of-network provider shall be reimbursed at the same rate and benefit level for the provided services as an in-network provider for the health benefit plan, HMO, PPO, or other provider network authorized to administer health care coverage in this state.

Added by Laws 2024, c. 359, § 1, emerg. eff. May 30, 2024.

NOTE: Editorially renumbered from § 6981 of this title to avoid duplication in numbering.

§36-7001. Short title - Purpose.

Sections 21 through 23 of this act shall constitute Article 70 of the Oklahoma Insurance Code and shall be known and may be cited as the "Health Savings Account Act". The purpose of this act is to enable citizens of Oklahoma to establish health savings accounts as permitted by Section 223 of the Internal Revenue Code as added by Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. 108-173.

Added by Laws 2005, c. 129, § 21, eff. Nov. 1, 2005.

§36-7002. Definitions.

As used in the Health Savings Account Act:

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

2. "State-mandated health benefits" means coverage for health care services or benefits, required by state law or state regulations, requiring the reimbursement or utilization related to a specific illness, injury, or condition of the covered person, or inclusion of a specific category of licensed health care practitioner to be provided to the covered person in a health benefit plan for a health-related condition of a covered person. Provided, that for the purposes of the options provided by this act, state-mandated health benefits which may be excluded in whole or in part shall not include any health care services or benefits which are mandated by federal law. "State-mandated health benefits" does not mean standard provisions or rights required to be present in a health benefit plan pursuant to state law or state regulations unrelated to a specific illness, injury or condition of the insured including, but not limited to, those related to continuation of benefits found in Article 45 of the Oklahoma Insurance Code. Added by Laws 2005, c. 129, § 22, eff. Nov. 1, 2005.

§36-7003. State-mandated health benefits - Exclusion.

Any insurance company, health maintenance organization or group health service organization that files a high deductible health benefit plan pursuant to Section 223(c)(2) of the Internal Revenue Code as added by Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. 108-173, shall not be required to offer coverage for any state-mandated health benefits as defined in Section 22 of this act. Added by Laws 2005, c. 129, § 23, eff. Nov. 1, 2005.

§36-7004. Interstate Insurance Product Regulation Compact.

A. Pursuant to terms and conditions of this act, the State of Oklahoma seeks to join with other states and establish the Interstate Insurance Product Regulation Compact, and thus become a member of the Interstate Insurance Product Regulation Commission.

B. The Insurance Commissioner of the State of Oklahoma is hereby designated to serve as the representative of this state to the Commission.

C. The Governor is hereby authorized and directed to execute a Compact on behalf of this state with any other state or states legally joining therein in the form substantially as follows:

INTERSTATE INSURANCE PRODUCT REGULATION COMPACT
ARTICLE I. PURPOSES

The purposes of this Compact are, through means of joint and cooperative action among the compacting states:

1. To promote and protect the interest of consumers of individual and group annuity, life insurance, disability income and long-term care insurance products;
2. To develop uniform standards for insurance products covered under the Compact;
3. To establish a central clearinghouse to receive and provide prompt review of insurance products covered under the Compact and, in certain cases, advertisements related thereto, submitted by insurers authorized to do business in one or more compacting states;
4. To give appropriate regulatory approval to those product filings and advertisements satisfying the applicable uniform standard;
5. To improve coordination of regulatory resources and expertise between state insurance departments regarding the setting of uniform standards and review of insurance products covered under the Compact;
6. To create the Interstate Insurance Product Regulation Commission; and
7. To perform these and such other related functions as may be consistent with the state regulation of the business of insurance.

ARTICLE II. DEFINITIONS

For purposes of this Compact:

1. "Advertisement" means any material designed to create public interest in a product, or induce the public to purchase, increase, modify, reinstate, borrow on, surrender, replace or retain a policy, as more specifically defined in the rules and operating procedures of the Commission;
2. "Bylaws" means those bylaws established by the Commission for its governance, or for directing or controlling the Commission's actions or conduct;
3. "Compacting state" means any state which has enacted this Compact legislation and which has not withdrawn pursuant to Section 1 of Article XIV of this Compact, or been terminated pursuant to Section 2 of Article XIV of this Compact;
4. "Commission" means the "Interstate Insurance Product Regulation Commission" established by this Compact;
5. "Commissioner" means the chief insurance regulatory official of a state including, but not limited to, commissioner, superintendent, director or administrator;
6. "Domiciliary state" means the state in which an insurer is incorporated or organized or, in the case of an alien insurer, its state of entry;
7. "Insurer" means any entity licensed by a state to issue contracts of insurance for any of the lines of insurance covered by this act;

8. "Member" means the person chosen by a compacting state as its representative to the Commission, or his or her designee;

9. "Noncompacting state" means any state which is not at the time a compacting state;

10. "Operating procedures" means procedures promulgated by the Commission implementing a rule, uniform standard or a provision of this Compact;

11. "Product" means the form of a policy or contract, including any application, endorsement, or related form which is attached to and made a part of the policy or contract, and any evidence of coverage or certificate, for an individual or group annuity, life insurance, disability income or long-term care insurance product that an insurer is authorized to issue;

12. "Rule" means a statement of general or particular applicability and future effect promulgated by the Commission, including a uniform standard developed pursuant to Article VII of this Compact, designed to implement, interpret, or prescribe law or policy or describing the organization, procedure, or practice requirements of the Commission, which shall have the force and effect of law in the compacting states;

13. "State" means any state, district or territory of the United States of America;

14. "Third-party filer" means an entity that submits a product filing to the Commission on behalf of an insurer; and

15. "Uniform standard" means a standard adopted by the Commission for a product line, pursuant to Article VII of this Compact, and shall include all of the product requirements in aggregate; provided, that each uniform standard shall be construed, whether express or implied, to prohibit the use of any inconsistent, misleading or ambiguous provisions in a product and the form of the product made available to the public shall not be unfair, inequitable or against public policy as determined by the Commission.

ARTICLE III. ESTABLISHMENT OF THE COMMISSION AND VENUE

1. The compacting states hereby create and establish a joint public agency known as the "Interstate Insurance Product Regulation Commission". Pursuant to Article IV of this Compact, the Commission will have the power to develop uniform standards for product lines, receive and provide prompt review of products filed therewith, and give approval to those product filings satisfying applicable uniform standards; provided, it is not intended for the Commission to be the exclusive entity for receipt and review of insurance product filings. Nothing herein shall prohibit any insurer from filing its product in any state wherein the insurer is licensed to conduct the business of insurance; and any such filing shall be subject to the laws of the state where filed.

2. The Commission is a body corporate and politic, and an instrumentality of the compacting states.

3. The Commission is solely responsible for its liabilities except as otherwise specifically provided in this Compact.

4. Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the Commission is located.

ARTICLE IV. POWERS OF THE COMMISSION

The Commission shall have the following powers:

1. To promulgate rules, pursuant to Article VII of this Compact, which shall have the force and effect of law and shall be binding in the compacting states to the extent and in the manner provided in this Compact;

2. To exercise its rulemaking authority and establish reasonable uniform standards for products covered under the Compact, and advertisement related thereto, which shall have the force and effect of law and shall be binding in the compacting states, but only for those products filed with the Commission; provided, that a compacting state shall have the right to opt out of such uniform standard pursuant to Article VII of this Compact, to the extent and in the manner provided in this Compact; and provided further, that any uniform standard established by the Commission for long-term care insurance products may provide the same or greater protections for consumers as, but shall not provide less than, those protections set forth in the National Association of Insurance Commissioners' Long-Term Care Insurance Model Act and Long-Term Care Insurance Model Regulation, respectively, adopted as of 2001. The Commission shall consider whether any subsequent amendments to the NAIC Long-Term Care Insurance Model Act or Long-Term Care Insurance Model Regulation adopted by the NAIC require amending of the uniform standards established by the Commission for long-term care insurance products;

3. To receive and review in an expeditious manner products filed with the Commission, and rate filings for disability income and long-term care insurance products, and give approval of those products and rate filings that satisfy the applicable uniform standard, where such approval shall have the force and effect of law and be binding on the compacting states to the extent and in the manner provided in the Compact;

4. To receive and review in an expeditious manner advertisement relating to long-term care insurance products for which uniform standards have been adopted by the Commission, and give approval to all advertisement that satisfies the applicable uniform standard. For any product covered under this Compact, other than long-term care insurance products, the Commission shall have the authority to require an insurer to submit all or any part of its advertisement

with respect to that product for review or approval prior to use, if the Commission determines that the nature of the product is such that an advertisement of the product could have the capacity or tendency to mislead the public. The actions of the Commission as provided in this section shall have the force and effect of law and shall be binding in the compacting states to the extent and in the manner provided in the Compact;

5. To exercise its rulemaking authority and designate products and advertisement that may be subject to a self-certification process without the need for prior approval by the Commission;

6. To promulgate operating procedures, pursuant to Article VII of this Compact, which shall be binding in the compacting states to the extent and in the manner provided in this Compact;

7. To bring and prosecute legal proceedings or actions in its name as the Commission; provided, that the standing of any state insurance department to sue or be sued under applicable law shall not be affected;

8. To issue subpoenas requiring the attendance and testimony of witnesses and the production of evidence;

9. To establish and maintain offices;

10. To purchase and maintain insurance and bonds;

11. To borrow, accept or contract for services of personnel, including, but not limited to, employees of a compacting state;

12. To hire employees, professionals or specialists, and elect or appoint officers, and to fix their compensation, define their duties and give them appropriate authority to carry out the purposes of the Compact, and determine their qualifications; and to establish the Commission's personnel policies and programs relating to, among other things, conflicts of interest, rates of compensation and qualifications of personnel;

13. To accept any and all appropriate donations and grants of money, equipment, supplies, materials and services, and to receive, utilize and dispose of the same; provided, that at all times the Commission shall strive to avoid any appearance of impropriety;

14. To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve or use, any property, real, personal or mixed; provided, that at all times the Commission shall strive to avoid any appearance of impropriety;

15. To sell, convey, mortgage, pledge, lease, exchange, abandon or otherwise dispose of any property, real, personal or mixed;

16. To remit filing fees to compacting states as may be set forth in the bylaws, rules or operating procedures;

17. To enforce compliance by compacting states with rules, uniform standards, operating procedures and bylaws;

18. To provide for dispute resolution among compacting states;

19. To advise compacting states on issues relating to insurers domiciled or doing business in noncompacting jurisdictions, consistent with the purposes of this Compact;

20. To provide advice and training to those personnel in state insurance departments responsible for product review, and to be a resource for state insurance departments;

21. To establish a budget and make expenditures;

22. To borrow money;

23. To appoint committees, including advisory committees comprising members, state insurance regulators, state legislators or their representatives, insurance industry and consumer representatives, and such other interested persons as may be designated in the bylaws;

24. To provide and receive information from, and to cooperate with, law enforcement agencies;

25. To adopt and use a corporate seal; and

26. To perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of the business of insurance.

ARTICLE V. ORGANIZATION OF THE COMMISSION

1. Membership, Voting and Bylaws:

- a. Each compacting state shall have and be limited to one member. Each member shall be qualified to serve in that capacity pursuant to applicable law of the compacting state. Any member may be removed or suspended from office as provided by the law of the state from which he or she shall be appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the compacting state wherein the vacancy exists. Nothing herein shall be construed to affect the manner in which a compacting state determines the election or appointment and qualification of its own Commissioner.
- b. Each member shall be entitled to one vote and shall have an opportunity to participate in the governance of the Commission in accordance with the bylaws. Notwithstanding any provision herein to the contrary, no action of the Commission with respect to the promulgation of a uniform standard shall be effective unless two-thirds (2/3) of the members vote in favor thereof.
- c. The Commission shall, by a majority of the members, prescribe bylaws to govern its conduct as may be necessary or appropriate to carry out the purposes, and exercise the powers, of the Compact, including, but not limited to:
 - i. Establishing the fiscal year of the Commission;

- ii. Providing reasonable procedures for appointing and electing members, as well as holding meetings, of the Management Committee;
- iii. Providing reasonable standards and procedures:
 - (1) for the establishment and meetings of other committees, and
 - (2) governing any general or specific delegation of any authority or function of the Commission;
- iv. Providing reasonable procedures for calling and conducting meetings of the Commission that consist of a majority of Commission members, ensuring reasonable advance notice of each such meeting and providing for the right of citizens to attend each such meeting with enumerated exceptions designed to protect the public's interest, the privacy of individuals, and insurers' proprietary information, including trade secrets. The Commission may meet in camera only after a majority of the entire membership votes to close a meeting en toto or in part. As soon as practicable, the Commission must make public:
 - (1) a copy of the vote to close the meeting revealing the vote of each member with no proxy votes allowed, and
 - (2) votes taken during such meeting;
- v. Establishing the titles, duties and authority and reasonable procedures for the election of the officers of the Commission;
- vi. Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the Commission. Notwithstanding any civil service or other similar laws of any compacting state, the bylaws shall exclusively govern the personnel policies and programs of the Commission;
- vii. Promulgating a code of ethics to address permissible and prohibited activities of Commission members and employees; and
- viii. Providing a mechanism for winding up the operations of the Commission and the equitable disposition of any surplus funds that may exist after the termination of the Compact after the payment and/or reserving of all of its debts and obligations.

- d. The Commission shall publish its bylaws in a convenient form and file a copy thereof and a copy of any amendment thereto with the appropriate agency or officer in each of the compacting states.
2. Management Committee, Officers and Personnel
- a. A Management Committee comprising no more than fourteen members shall be established as follows:
 - i. One member from each of the six compacting states with the largest premium volume for individual and group annuities, life, disability income and long-term care insurance products, determined from the records of the NAIC for the prior year;
 - ii. Four members from those compacting states with at least two percent (2%) of the market based on the premium volume described above, other than the six compacting states with the largest premium volume, selected on a rotating basis as provided in the bylaws; and
 - iii. Four members from those compacting states with less than two percent (2%) of the market, based on the premium volume described above, with one selected from each of the four zone regions of the NAIC as provided in the bylaws.
 - b. The Management Committee shall have such authority and duties as may be set forth in the bylaws including, but not limited to:
 - i. Managing the affairs of the Commission in a manner consistent with the bylaws and purposes of the Commission;
 - ii. Establishing and overseeing an organizational structure within, and appropriate procedures for, the Commission to provide for the creation of uniform standards and other rules, receipt and review of product filings, administrative and technical support functions, review of decisions regarding the disapproval of a product filing, and the review of elections made by a compacting state to opt out of uniform standard; provided, that a uniform standard shall not be submitted to the compacting states for adoption unless approved by two-thirds (2/3) of the members of the Management Committee;
 - iii. Overseeing the offices of the Commission; and
 - iv. Planning, implementing, and coordinating communications and activities with other state, federal and local government organizations in order to advance the goals of the Commission.

- c. The Commission shall elect annually officers from the Management Committee, with each having such authority and duties as may be specified in the bylaws.
- d. The Management Committee may, subject to the approval of the Commission, appoint or retain an executive director for such period, upon such terms and conditions and for such compensation as the Commission may deem appropriate. The executive director shall serve as secretary to the Commission, but shall not be a member of the Commission. The executive director shall hire and supervise such other staff as may be authorized by the Commission.

3. Legislative and Advisory Committees

- a. A legislative committee comprising state legislators or their designees shall be established to monitor the operations of, and make recommendations to, the Commission, including the Management Committee; provided, that the manner of selection and term of any legislative committee member shall be as set forth in the bylaws. Prior to the adoption by the Commission of any uniform standard, revision to the bylaws, annual budget or other significant matter as may be provided in the bylaws, the Management Committee shall consult with and report to the legislative committee.
- b. The Commission shall establish two advisory committees, one of which shall comprise consumer representatives independent of the insurance industry, and the other comprising insurance industry representatives.
- c. The Commission may establish additional advisory committees as its bylaws may provide for the carrying out of its functions.

4. Corporate Records of the Commission

The Commission shall maintain its corporate books and records in accordance with the bylaws.

5. Qualified Immunity, Defense and Indemnification

- a. The members, officers, executive director, employees and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred, within the scope of Commission employment, duties or responsibilities; provided, that nothing in this

paragraph shall be construed to protect any such person from suit and/or liability for any damage, loss, injury or liability caused by the intentional or willful and wanton misconduct of that person.

- b. The Commission shall defend any member, officer, executive director, employee or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided, that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and provided further, that the actual or alleged act, error or omission did not result from that person's intentional or willful and wanton misconduct.
- c. The Commission shall indemnify and hold harmless any member, officer, executive director, employee or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities, provided that the actual or alleged act, error or omission did not result from the intentional or willful and wanton misconduct of that person.

ARTICLE VI. MEETINGS AND ACTS OF THE COMMISSION

1. The Commission shall meet and take such actions as are consistent with the provisions of this Compact and the bylaws.

2. Each member of the Commission shall have the right and power to cast a vote to which that compacting state is entitled and to participate in the business and affairs of the Commission. A member shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for members' participation in meetings by telephone or other means of communication.

3. The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the bylaws.

ARTICLE VII. RULES AND OPERATING PROCEDURES:

RULEMAKING FUNCTIONS OF THE COMMISSION AND OPTING OUT OF UNIFORM STANDARDS

1. Rulemaking Authority. The Commission shall promulgate reasonable rules, including uniform standards, and operating procedures in order to effectively and efficiently achieve the purposes of this Compact. Notwithstanding the foregoing, in the event the Commission exercises its rulemaking authority in a manner that is beyond the scope of the purposes of this act, or the powers granted hereunder, then such an action by the Commission shall be invalid and have no force and effect.

2. Rulemaking Procedure. Rules and operating procedures shall be made pursuant to a rulemaking process that conforms to the Model State Administrative Procedure Act of 1981 as amended, as may be appropriate to the operations of the Commission. Before the Commission adopts a uniform standard, the Commission shall give written notice to the relevant state legislative committee(s) in each compacting state responsible for insurance issues of its intention to adopt the uniform standard. The Commission in adopting a uniform standard shall consider fully all submitted materials and issue a concise explanation of its decision.

3. Effective Date and Opt Out of a Uniform Standard. A uniform standard shall become effective ninety (90) days after its promulgation by the Commission or such later date as the Commission may determine; provided, however, that a compacting state may opt out of a uniform standard as provided in this Article. "Opt out" shall be defined as any action by a compacting state to decline to adopt or participate in a promulgated uniform standard. All other rules and operating procedures, and amendments thereto, shall become effective as of the date specified in each rule, operating procedure or amendment.

4. Opt Out Procedure. A compacting state may opt out of a uniform standard, either by legislation or regulation duly promulgated by the Insurance Department under the compacting state's Administrative Procedure Act. If a compacting state elects to opt out of a uniform standard by regulation, it must:

- a. Give written notice to the Commission no later than ten (10) business days after the uniform standard is promulgated, or at the time the state becomes a compacting state; and
- b. Find that the uniform standard does not provide reasonable protections to the citizens of the state, given the conditions in the state. The Commissioner shall make specific findings of fact and conclusions of law, based on a preponderance of the evidence, detailing the conditions in the state which warrant a departure from the uniform standard and determining that the uniform standard would not reasonably protect the citizens of the state. The Commissioner must consider and balance the following factors and find

that the conditions in the state and needs of the citizens of the state outweigh:

- i. The intent of the Legislature to participate in, and the benefits of, an interstate agreement to establish national uniform consumer protections for the products subject to this act; and
- ii. The presumption that a uniform standard adopted by the Commission provides reasonable protections to consumers of the relevant product.

Notwithstanding the foregoing, a compacting state may, at the time of its enactment of this Compact, prospectively opt out of all uniform standards involving long-term care insurance products by expressly providing for such opt out in the enacted Compact, and such an opt out shall not be treated as a material variance in the offer or acceptance of any state to participate in this Compact. Such an opt out shall be effective at the time of enactment of this Compact by the compacting state and shall apply to all existing uniform standards involving long-term care insurance products and those subsequently promulgated.

5. Effect of Opt Out. If a compacting state elects to opt out of a uniform standard, the uniform standard shall remain applicable in the compacting state electing to opt out until such time the opt out legislation is enacted into law or the regulation opting out becomes effective.

Once the opt out of a uniform standard by a compacting state becomes effective as provided under the laws of that state, the uniform standard shall have no further force and effect in that state unless and until the legislation or regulation implementing the opt out is repealed or otherwise becomes ineffective under the laws of the state. If a compacting state opts out of a uniform standard after the uniform standard has been made effective in that state, the opt out shall have the same prospective effect as provided under Article XIV of this Compact for withdrawals.

6. Stay of Uniform Standard. If a compacting state has formally initiated the process of opting out of a uniform standard by regulation, and while the regulatory opt out is pending, the compacting state may petition the Commission, at least fifteen (15) days before the effective date of the uniform standard, to stay the effectiveness of the uniform standard in that state. The Commission may grant a stay if it determines the regulatory opt out is being pursued in a reasonable manner and there is a likelihood of success. If a stay is granted or extended by the Commission, the stay or extension thereof may postpone the effective date by up to ninety (90) days, unless affirmatively extended by the Commission; provided, a stay may not be permitted to remain in effect for more than one (1) year unless the compacting state can show extraordinary circumstances which warrant a continuance of the stay, including,

but not limited to, the existence of a legal challenge which prevents the compacting state from opting out. A stay may be terminated by the Commission upon notice that the rulemaking process has been terminated.

7. Not later than thirty (30) days after a rule or operating procedure is promulgated, any person may file a petition for judicial review of the rule or operating procedure; provided, that the filing of such a petition shall not stay or otherwise prevent the rule or operating procedure from becoming effective unless the court finds that the petitioner has a substantial likelihood of success. The court shall give deference to the actions of the Commission consistent with applicable law and shall not find the rule or operating procedure to be unlawful if the rule or operating procedure represents a reasonable exercise of the Commission's authority.

ARTICLE VIII. COMMISSION RECORDS AND ENFORCEMENT

1. The Commission shall promulgate rules establishing conditions and procedures for public inspection and copying of its information and official records, except such information and records involving the privacy of individuals and insurers' trade secrets. The Commission may promulgate additional rules under which it may make available to federal and state agencies, including law enforcement agencies, records and information otherwise exempt from disclosure, and may enter into agreements with such agencies to receive or exchange information or records subject to nondisclosure and confidentiality provisions.

2. Except as to privileged records, data and information, the laws of any compacting state pertaining to confidentiality or nondisclosure shall not relieve any compacting state Commissioner of the duty to disclose any relevant records, data or information to the Commission; provided, that disclosure to the Commission shall not be deemed to waive or otherwise affect any confidentiality requirement; and further provided, that, except as otherwise expressly provided in this act, the Commission shall not be subject to the compacting state's laws pertaining to confidentiality and nondisclosure with respect to records, data and information in its possession. Confidential information of the Commission shall remain confidential after such information is provided to any Commissioner.

3. The Commission shall monitor compacting states for compliance with duly adopted bylaws, rules, including uniform standards, and operating procedures. The Commission shall notify any noncomplying compacting state in writing of its noncompliance with Commission bylaws, rules or operating procedures. If a noncomplying compacting state fails to remedy its noncompliance within the time specified in the notice of noncompliance, the compacting state shall be deemed to be in default as set forth in Article XIV of this Compact.

4. The Commissioner of any state in which an insurer is authorized to do business, or is conducting the business of insurance, shall continue to exercise his or her authority to oversee the market regulation of the activities of the insurer in accordance with the provisions of the state's law. The Commissioner's enforcement of compliance with the Compact is governed by the following provisions:

- a. With respect to the Commissioner's market regulation of a product or advertisement that is approved or certified to the Commission, the content of the product or advertisement shall not constitute a violation of the provisions, standards or requirements of the Compact except upon a final order of the Commission, issued at the request of a Commissioner after prior notice to the insurer and an opportunity for hearing before the Commission.
- b. Before a Commissioner may bring an action for violation of any provision, standard or requirement of the Compact relating to the content of an advertisement not approved or certified to the Commission, the Commission, or an authorized Commission officer or employee, must authorize the action. However, authorization pursuant to this paragraph does not require notice to the insurer, opportunity for hearing or disclosure of requests for authorization or records of the Commission's action on such requests.

ARTICLE IX. DISPUTE RESOLUTION

The Commission shall attempt, upon the request of a member, to resolve any disputes or other issues that are subject to this Compact and which may arise between two or more compacting states, or between compacting states and noncompacting states, and the Commission shall promulgate an operating procedure providing for resolution of such disputes.

ARTICLE X. PRODUCT FILING AND APPROVAL

1. Insurers and third-party filers seeking to have a product approved by the Commission shall file the product with, and pay applicable filing fees to, the Commission. Nothing in this act shall be construed to restrict or otherwise prevent an insurer from filing its product with the insurance department in any state wherein the insurer is licensed to conduct the business of insurance, and such filing shall be subject to the laws of the states where filed.

2. The Commission shall establish appropriate filing and review processes and procedures pursuant to Commission rules and operating procedures. Notwithstanding any provision herein to the contrary, the Commission shall promulgate rules to establish conditions and

procedures under which the Commission will provide public access to product filing information. In establishing such rules, the Commission shall consider the interests of the public in having access to such information, as well as protection of personal medical and financial information and trade secrets, that may be contained in a product filing or supporting information.

3. Any product approved by the Commission may be sold or otherwise issued in those compacting states for which the insurer is legally authorized to do business.

ARTICLE XI. REVIEW OF COMMISSION DECISIONS REGARDING FILINGS

1. Not later than thirty (30) days after the Commission has given notice of a disapproved product or advertisement filed with the Commission, the insurer or third-party filer whose filing was disapproved may appeal the determination to a review panel appointed by the Commission. The Commission shall promulgate rules to establish procedures for appointing such review panels and provide for notice and hearing. An allegation that the Commission, in disapproving a product or advertisement filed with the Commission, acted arbitrarily, capriciously, or in a manner that is an abuse of discretion or otherwise not in accordance with the law, is subject to judicial review in accordance with Section 4 of Article III of this Compact.

2. The Commission shall have authority to monitor, review and reconsider products and advertisement subsequent to their filing or approval upon a finding that the product does not meet the relevant uniform standard. Where appropriate, the Commission may withdraw or modify its approval after proper notice and hearing, subject to the appeal process in Section 1 of this article.

ARTICLE XII. FINANCE

1. The Commission shall pay or provide for the payment of the reasonable expenses of its establishment and organization. To fund the cost of its initial operations, the Commission may accept contributions and other forms of funding from the National Association of Insurance Commissioners, compacting states and other sources. Contributions and other forms of funding from other sources shall be of such a nature that the independence of the Commission concerning the performance of its duties shall not be compromised.

2. The Commission shall collect a filing fee from each insurer and third-party filer filing a product with the Commission to cover the cost of the operations and activities of the Commission and its staff in a total amount sufficient to cover the Commission's annual budget.

3. The Commission's budget for a fiscal year shall not be approved until it has been subject to notice and comment as set forth in Article VII of this Compact.

4. The Commission shall be exempt from all taxation in and by the compacting states.

5. The Commission shall not pledge the credit of any compacting state, except by and with the appropriate legal authority of that compacting state.

6. The Commission shall keep complete and accurate accounts of all its internal receipts, including grants and donations, and disbursements of all funds under its control. The internal financial accounts of the Commission shall be subject to the accounting procedures established under its bylaws. The financial accounts and reports including the system of internal controls and procedures of the Commission shall be audited annually by an independent certified public accountant. Upon the determination of the Commission, but no less frequently than every three (3) years, the review of the independent auditor shall include a management and performance audit of the Commission. The Commission shall make an annual report to the Governor and Legislature of the compacting states, which shall include a report of the independent audit. The Commission's internal accounts shall not be confidential and such materials may be shared with the Commissioner of any compacting state upon request; provided, however, that any work papers related to any internal or independent audit and any information regarding the privacy of individuals and insurers' proprietary information, including trade secrets, shall remain confidential.

7. No compacting state shall have any claim to or ownership of any property held by or vested in the Commission or to any Commission funds held pursuant to the provisions of this Compact.

ARTICLE XIII. COMPACTING STATES, EFFECTIVE DATE AND AMENDMENT

1. Any state is eligible to become a compacting state.

2. The Compact shall become effective and binding upon legislative enactment of the Compact into law by two compacting states; provided, the Commission shall become effective for purposes of adopting uniform standards for, reviewing, and giving approval or disapproval of, products filed with the Commission that satisfy applicable uniform standards only after twenty-six (26) states are compacting states or, alternatively, by states representing greater than forty percent (40%) of the premium volume for life insurance, annuity, disability income and long-term care insurance products, based on records of the NAIC for the prior year. Thereafter, it shall become effective and binding as to any other compacting state upon enactment of the Compact into law by that state.

3. Amendments to the Compact may be proposed by the Commission for enactment by the compacting states. No amendment shall become effective and binding upon the Commission and the compacting states unless and until all compacting states enact the amendment into law.

ARTICLE XIV. WITHDRAWAL, DEFAULT AND TERMINATION

1. Withdrawal

- a. Once effective, the Compact shall continue in force and remain binding upon each and every compacting state; provided, that a compacting state may withdraw from the Compact ("withdrawing state") by enacting a statute specifically repealing the statute which enacted the Compact into law.
- b. The effective date of withdrawal is the effective date of the repealing statute. However, the withdrawal shall not apply to any product filings approved or self-certified, or any advertisement of such products, on the date the repealing statute becomes effective, except by mutual agreement of the Commission and the withdrawing state unless the approval is rescinded by the withdrawing state as provided in paragraph e of this section.
- c. The Commissioner of the withdrawing state shall immediately notify the Management Committee in writing upon the introduction of legislation repealing this Compact in the withdrawing state.
- d. The Commission shall notify the other compacting states of the introduction of such legislation within ten (10) days after its receipt of notice thereof.
- e. The withdrawing state is responsible for all obligations, duties and liabilities incurred through the effective date of withdrawal, including any obligations, the performance of which extend beyond the effective date of withdrawal, except to the extent those obligations may have been released or relinquished by mutual agreement of the Commission and the withdrawing state. The Commission's approval of products and advertisement prior to the effective date of withdrawal shall continue to be effective and be given full force and effect in the withdrawing state, unless formally rescinded by the withdrawing state in the same manner as provided by the laws of the withdrawing state for the prospective disapproval of products or advertisement previously approved under state law.
- f. Reinstatement following withdrawal of any compacting state shall occur upon the effective date of the withdrawing state reenacting the Compact.

2. Default

- a. If the Commission determines that any compacting state has at any time defaulted ("defaulting state") in the performance of any of its obligations or responsibilities under this Compact, the bylaws or duly promulgated rules or operating procedures, then,

after notice and hearing as set forth in the bylaws, all rights, privileges and benefits conferred by this Compact on the defaulting state shall be suspended from the effective date of default as fixed by the Commission. The grounds for default include, but are not limited to, failure of a compacting state to perform its obligations or responsibilities, and any other grounds designated in Commission rules. The Commission shall immediately notify the defaulting state in writing of the defaulting state's suspension pending a cure of the default. The Commission shall stipulate the conditions and the time period within which the defaulting state must cure its default. If the defaulting state fails to cure the default within the time period specified by the Commission, the defaulting state shall be terminated from the Compact and all rights, privileges and benefits conferred by this Compact shall be terminated from the effective date of termination.

- b. Product approvals by the Commission or product self-certifications, or any advertisement in connection with such product, that is in force on the effective date of termination shall remain in force in the defaulting state in the same manner as if the defaulting state had withdrawn voluntarily pursuant to Section 1 of this article.
- c. Reinstatement following termination of any compacting state requires a reenactment of the Compact.

3. Dissolution of Compact

- a. The Compact dissolves effective upon the date of the withdrawal or default of the compacting state which reduces membership in the Compact to one compacting state.
- b. Upon the dissolution of this Compact, the Compact becomes null and void and shall be of no further force or effect, and the business and affairs of the Commission shall be wound up and any surplus funds shall be distributed in accordance with the bylaws.

ARTICLE XV. SEVERABILITY AND CONSTRUCTION

1. The provisions of this Compact shall be severable; and if any phrase, clause, sentence or provision is deemed unenforceable, the remaining provisions of the Compact shall be enforceable.

2. The provisions of this Compact shall be liberally construed to effectuate its purposes.

ARTICLE XVI. BINDING EFFECT OF COMPACT AND OTHER LAWS

- 1. Other Laws

- a. Nothing herein prevents the enforcement of any other law of a compacting state, except as provided in paragraph b of this section.
 - b. For any product approved or certified to the Commission, the rules, uniform standards and any other requirements of the Commission shall constitute the exclusive provisions applicable to the content, approval and certification of such products. For advertisement that is subject to the Commission's authority, any rule, uniform standard or other requirement of the Commission which governs the content of the advertisement shall constitute the exclusive provision that a Commissioner may apply to the content of the advertisement. Notwithstanding the foregoing, no action taken by the Commission shall abrogate or restrict:
 - i. the access of any person to state courts,
 - ii. remedies available under state law related to breach of contract, tort, or other laws not specifically directed to the content of the product,
 - iii. state law relating to the construction of insurance contracts, or
 - iv. the authority of the Attorney General of the state including, but not limited to, maintaining any actions or proceedings, as authorized by law.
 - c. All insurance products filed with individual states shall be subject to the laws of those states.
2. Binding Effect of this Compact
- a. All lawful actions of the Commission, including all rules and operating procedures promulgated by the Commission, are binding upon the compacting states.
 - b. All agreements between the Commission and the compacting states are binding in accordance with their terms.
 - c. Upon the request of a party to a conflict over the meaning or interpretation of Commission actions, and upon a majority vote of the compacting states, the Commission may issue advisory opinions regarding the meaning or interpretation in dispute.
 - d. In the event any provision of the Compact exceeds the constitutional limits imposed on the Legislature of any compacting state, the obligations, duties, powers or jurisdiction sought to be conferred by that provision upon the Commission shall be ineffective as to that compacting state, and those obligations, duties, powers or jurisdiction shall remain in the

compacting state and shall be exercised by the agency thereof to which those obligations, duties, powers or jurisdiction are delegated by law in effect at the time this Compact becomes effective.

Added by Laws 2006, c. 32, § 1.

§36-7101. Perpetual Care Fund Act.

Sections 7101 through 7112 of this title shall be known and may be cited as the "Perpetual Care Fund Act".

Added by Laws 1953, p. 16, § 1, emerg. eff. May 19, 1953. Amended by Laws 2010, c. 58, § 1, eff. July 1, 2010. Renumbered from § 161 of Title 8 by Laws 2010, c. 58, § 26, eff. July 1, 2010. Amended by Laws 2013, c. 269, § 16, eff. Nov. 1, 2013.

§36-7102. Definitions

As used in the Perpetual Care Fund Act:

1. "Cemetery" or "cemeteries" means any land or structure in this state dedicated to or used, or intended to be used, for the interment of human remains;

2. "Burial space" means any grave space, lot, mausoleum crypt or niche, whether above or below ground, which is used or intended to be used for the interment of human remains;

3. "Purchase price" means the gross dollar amount the customer shall pay the cemetery under a contractual agreement between the two to exchange ownership of, or rights to, certain burial spaces. Purchase price shall not include finance charges, sales tax, charges for credit life insurance, opening and closing costs and setting fees, but shall include any amount which the customer is required to pay as a deposit to the Perpetual Care Fund, described in Section 7103 of this title. On sales of burial spaces wherein discounts or free spaces are granted to the customer by the cemetery, the purchase price shall be the fair market value or the normal selling price of that particular type of burial space as sold by the cemetery;

4. "Financial institution" means a federally insured bank or savings and loan authorized to exercise trust powers or a trust company that is authorized to do business in this state;

5. "Income", except as provided in subsection D of Section 7103 of this title, means the return derived from the principal amount, excluding capital gains;

6. "Insurance Commissioner" or "Commissioner" means the Insurance Commissioner of the State of Oklahoma; and

7. "Designated agent" means one or more individuals designated by the cemetery owner and whom the owner has acknowledged as having fiduciary responsibilities under the Perpetual Care Fund Act.

Added by Laws 1953, p. 16, § 2, emerg. eff. May 19, 1953. Amended by Laws 1993, c. 218, § 1, eff. Sept. 1, 1993; Laws 2008, c. 275, §

7, eff. July 1, 2008; Laws 2010, c. 58, § 2, eff. July 1, 2010. Renumbered from § 162 of Title 8 by Laws 2010, c. 58, § 27, eff. July 1, 2010. Amended by Laws 2013, c. 269, § 17, eff. Nov. 1, 2013; Laws 2016, c. 118, § 3, eff. Nov. 1, 2016.

§36-7103. Perpetual Care Fund - Deposits into fund - Investments - Distribution methods

A. In all cemeteries in this state where burial spaces are sold, not less than ten percent (10%) of the purchase price thereof shall be segregated and set aside as a permanent trust fund to be known as the "Perpetual Care Fund". The Perpetual Care Fund shall be invested as hereinafter prescribed, and the income only shall be used in improving, caring for, and embellishing the lots, walks, drives, parks and other improvements in the cemeteries and maintenance of office and care of records.

B. If a cemetery allows a person or other entity to construct or otherwise establish a burial space at the cemetery that is not purchased from the cemetery, the cemetery shall collect from the person or entity an amount not less than ten percent (10%) of the construction or retail cost of the burial space, to be deposited in the Perpetual Care Fund of the cemetery.

C. The owner or designated agent of a cemetery shall set aside and deposit the amounts required in subsections A and B of this section in a financial institution authorized by law, as trustee, to administer the trusts, not later than thirty (30) days after the close of the month in which was received the final payment on the purchase price of each burial space. The amounts shall be held by the trustee of the Perpetual Care Fund in trust for the specific purposes stated in a written trust agreement. The trust agreement may provide for an individual or other entity to exist as cotrustee; provided, however, in no instance shall the cotrustee have sole access to deposits held in the Perpetual Care Fund, except as otherwise provided in this act.

D. Notwithstanding the requirements of subsection C of this section, if the total amount of the Perpetual Care Fund maintained by the cemetery is an amount equal to or less than the standard insurance amount per depositor as provided by the Federal Deposit Insurance Corporation, the cemetery may, in lieu of depositing the funds in a trust account, purchase a certificate of deposit from a financial institution according to the terms of this subsection. The certificate of deposit shall be pledged in favor of the Oklahoma Insurance Department with no right of withdrawal by the cemetery, whether before or after maturity, except upon application to, and approval by, the Insurance Commissioner. The terms of the certificate of deposit shall provide for notice to the Insurance Department within thirty (30) days prior to maturity. Only interest accruing from the certificate of deposit may be withdrawn by the

cemetery and shall be considered income for purposes of subsection A of this section. If a cemetery maintains a certificate of deposit in lieu of a trust fund, as it collects funds which are required to be deposited into its Perpetual Care Fund, it shall segregate those funds from its other operating funds and contribute those funds to the certificate of deposit upon its next maturity date. If a Perpetual Care Fund of a cemetery is maintained in a certificate of deposit, but grows in an amount greater than the standard insurance amount per depositor as provided by the Federal Deposit Insurance Corporation, the cemetery shall comply with the provisions of subsection C of this section by placing all of its Perpetual Care Fund in trust and shall no longer maintain a certificate of deposit as authorized by this subsection.

E. A cemetery regulated under this section may choose distribution from the perpetual care fund in the form of either all net ordinary income or an amount, not to be reduced by taxes or fees, not exceeding five percent (5%) of the average fair market value of the trust funds.

1. A cemetery may select a distribution method by delivering written instructions to the trustee of the fund no later than thirty (30) days prior to the beginning of the calendar year. Such notification shall also be provided to the Insurance Commissioner. The distribution method and distribution rate selected shall remain in effect unless the cemetery notifies the trustee and the Insurance Commissioner of its desire to effect a change.

2. Disbursements from the trust shall be made on a monthly, quarterly, semi-annual or annual basis, as agreed upon by the cemetery and the trustee.

3. In the event that the trustee does not receive written instructions from the cemetery informing the trustee of the method of calculation chosen, then the trustee shall calculate and disburse the net ordinary income, as earned, on a monthly basis.

4. If the cemetery company selects a distribution based on the average fair market value calculation, the trustees must ensure that an investment policy is in place whose goals and objectives are supportive of the growth of the care and maintenance fund. In order to withdraw up to five percent (5%) of trust funds, the current market value of the trust after the withdrawal shall be greater than the aggregate of eighty percent (80%) of the market value of the trust as of the preceding calendar year, plus the total contributions made to trust principal from such date to the date that the method of calculation is selected. If this is not the case, distributions will be limited for that year to the net ordinary income.

5. The Insurance Commissioner may limit or prohibit the distribution based on average fair market value calculation in situations where investment returns and distribution practices have

not resulted in sufficient protection of the care fund's trust principal from a three to five year analysis, or where the trustee and any investment manager are not able to demonstrate sufficient knowledge and expertise regarding the effective implementation of distributing income for the maintenance of the cemetery using this method.

F. Without regard to the withdrawal method selected pursuant to subsection E of this section, capital gains taxes shall be paid from the trust principal.

Added by Laws 1953, p. 16, § 3, emerg. eff. May 19, 1953. Amended by Laws 1993, c. 218, § 2, eff. Sept. 1, 1993; Laws 2007, c. 80, § 9, eff. Jan. 1, 2008; Laws 2008, c. 275, § 8, eff. July 1, 2008; Laws 2010, c. 58, § 3, eff. July 1, 2010. Renumbered from Title 8, § 163 by Laws 2010, c. 58, § 28, eff. July 1, 2010; Amended by Laws 2016, c. 118, § 4, eff. Nov. 1, 2016.

§36-7104. Donations, deposits or bequests in trust.

Donations, deposits or bequests may be made in trust by mutual agreement between the cemetery and lot owner or lot owners, for the special care of specified lots, monuments or mausoleums in any such cemetery, and such funds shall be invested in like manner as the Perpetual Care Fund, but a separate account shall be kept of each amount so deposited, donated and bequeathed and only the income derived from such funds shall be used in the care, maintenance and repair of such lots, monuments and mausoleums, unless otherwise provided by the donor.

Added by Laws 1953, p. 16, § 4, emerg. eff. May 19, 1953.

Renumbered from Title 8, § 164 by Laws 2010, c. 58, § 29, eff. July 1, 2010.

§36-7105. Investment of trust funds - Income

Accumulated trust funds held by the trustee of the Perpetual Care Fund shall be invested in the manner provided in the Oklahoma Trust Act, Sections 175.1 through 175.57 of Title 60 of the Oklahoma Statutes, and any amendments thereto. The income derived therefrom shall be returned to the cemeteries to be used by them only as provided by the Perpetual Care Fund Act and in a manner consistent with elections made pursuant to subsection E of Section 7103 of this title.

Added by Laws 1953, p. 17, § 5, emerg. eff. May 19, 1953. Amended by Laws 1995, c. 82, § 1, eff. Nov. 1, 1995; Laws 2010, c. 58, § 4, eff. July 1, 2010. Renumbered from Title 8, § 165 by Laws 2010, c. 58, § 30, eff. July 1, 2010; Amended by Laws 2016, c. 118, § 5, eff. Nov. 1, 2016.

§36-7106. Permit required - Annual fee and report - Examination of books and records.

A. No owner of a cemetery shall maintain a Perpetual Care Trust Fund, or certificate of deposit in lieu of a Perpetual Care Trust Fund, unless the owner has received a permit from the Insurance Commissioner. Initial and renewal permit applications shall be filed electronically in the manner and form prescribed by the Commissioner, along with a two-hundred-dollar application fee and any transaction or other applicable fees. The permit shall expire on March 15 of each calendar year unless it is renewed by the permit holder. A permit expired for failure to submit a renewal application and fee may be reinstated within ninety (90) days after the expiration date by electronically filing a renewal application, paying a fee in an amount that is double the renewal fee, and paying any transaction or other applicable fees in the form and manner prescribed by the Commissioner. The Commissioner shall require a permit holder whose permit has been expired for more than ninety (90) days to reapply as if a new applicant and pay an application fee equal to an amount that is double the renewal fee, in addition to any other fines imposed. Any application received after the permit has been expired for more than ninety (90) days shall include a detailed report of Perpetual Care Trust Fund services provided in this state during the period that the permit was expired.

B. The owner of a cemetery maintaining a Perpetual Care Trust Fund or certificate of deposit in lieu of a Perpetual Care Trust Fund shall, by March 15 of each calendar year, electronically file a report and pay any applicable fees in the manner and form prescribed by the Commissioner. Such report shall show, for the preceding calendar year:

1. The gross amount received from sales of grave spaces, lots, mausoleum crypts and niches;

2. The total purchase price of grave spaces, lots, mausoleum crypts and niches on contracts which received final payment and required deposits to the Perpetual Care Fund during the calendar year;

3. The operating expenses incurred during the calendar year which are eligible to be paid from income of the Perpetual Care Fund;

4. The total amount of the principal of the Perpetual Care Fund as of the beginning of the preceding calendar year; and

5. The amount segregated and deposited in the Perpetual Care Fund as provided by the Perpetual Care Fund Act which, if the Perpetual Care Fund is held in trust, shall be certified by the trustee of the Perpetual Care Fund as to correctness thereof, and the trustee shall provide:

- a. the total amount of the principal of the Perpetual Care Fund as of the end of the calendar year,
- b. the securities and other assets in which such perpetual care funds are invested,

- c. the cash on hand,
- d. a verification in writing of all assets in which monies of the Perpetual Care Fund have been invested; provided, the verification shall be obtained from the holder or holders of the assets,
- e. the income derived from the Perpetual Care Fund investments during the calendar year, and
- f. the gross expenditures or transfers from income of the Perpetual Care Fund during the calendar year.

The annual fee collected pursuant to this subsection shall be deposited in the State Insurance Commissioner Revolving Fund created pursuant to Section 307.3 of this title.

C. If the Perpetual Care Fund is maintained in a certificate of deposit in lieu of a trust fund, the cemetery shall provide in its annual report a verification from the financial institution as to the amount of principal of the Perpetual Care Fund as of the end of the calendar year, and the amount of funds contributed to the certificate of deposit by the cemetery as of each maturity date of the certificate of deposit during the last calendar year.

D. The Commissioner shall have authority, at any time, to inspect the books and records of any cemetery, and to make an examination thereof for the purpose of determining if proper sums have been deposited with the trustee in the Perpetual Care Fund, or in a certificate of deposit maintained in lieu of a trust fund, and if the Fund is being properly administered by the trustee in accordance with the provisions of the Perpetual Care Fund Act and rules of the Commissioner. The examination shall be conducted pursuant to Sections 309.1 through 309.7 of this title and the cost of the examination shall be paid by the cemetery owner. The cost of the examination shall be billed directly to the cemetery owner by the examiner. Each cemetery owner and trustee is responsible for maintaining satisfactory books and records which adequately justify all information contained in the annual report required by this section.

E. Whenever a cemetery owner and/or trustee refuses to submit the books, records, papers, and instruments of the cemetery to the examination and inspection of the assistants or examiners of the Insurance Commissioner, or refuses or neglects to establish or maintain a Perpetual Care Trust Fund in accordance with the requirements of the Perpetual Care Fund Act within ninety (90) days after a written demand to establish or maintain a Perpetual Care Fund is made by the Commissioner, or in any manner obstructs or interferes with the examination of its cemetery or refuses to be examined on oath concerning any of the affairs of its cemetery, the Commissioner may make application for receivership in the manner of a domestic insurer pursuant to Sections 1901 through 1920 of this title.

Added by Laws 1953, p. 17, § 6, emerg. eff. May 19, 1953. Amended by Laws 1993, c. 218, § 3, eff. Sept. 1, 1993; Laws 1995, c. 82, § 2, eff. Nov. 1, 1995; Laws 2000, c. 205, § 28, emerg. eff. May 17, 2000; Laws 2005, c. 48, § 23, eff. Nov. 1, 2005; Laws 2007, c. 80, § 10, eff. Jan. 1, 2008; Laws 2010, c. 58, § 5, eff. July 1, 2010. Renumbered from Title 8, § 166 by Laws 2010, c. 58, § 31, eff. July 1, 2010; Amended by Laws 2016, c. 118, § 2, eff. Nov. 1, 2016; Laws 2023, c. 213, § 1, eff. Nov. 1, 2023.

§36-7107. Prepayment contract finance charges - Disclosure.

Every cemetery which provides prepayment financing programs to its customers under contracts in which a finance charge is made shall comply with all applicable provisions of the Uniform Consumer Credit Code, Sections 1-101 through 9-101 of Title 14A of the Oklahoma Statutes.

Added by Laws 1993, c. 218, § 4, eff. Sept. 1, 1993. Amended by Laws 2010, c. 58, § 6, eff. July 1, 2010. Renumbered from Title 8, § 167.1 by Laws 2010, c. 58, § 32, eff. July 1, 2010.

§36-7108. Exceptions to application of act.

A. The provisions of the Perpetual Care Fund Act shall not apply to municipal, religious, fraternal, or nonprofit entities, free community burial grounds, county cemetery associations, Indian tribal cemeteries on tribal land and charitable or eleemosynary institutions operating cemeteries in this state.

B. The provisions of the Perpetual Care Fund Act may apply to unincorporated cemetery associations operating cemeteries in this state. Unincorporated cemetery associations that make application with the Insurance Commissioner to maintain a perpetual care fund and are approved by the Commissioner shall comply with all provisions of the Perpetual Care Fund Act.

Added by Laws 1953, p. 17, § 8, emerg. eff. May 19, 1953. Amended by Laws 1995, c. 82, § 3, eff. Nov. 1, 1995; Laws 1999, c. 196, § 1, emerg. eff. May 24, 1999; Laws 2009, c. 3, § 4, eff. July 1, 2009; Laws 2010, c. 58, § 7, eff. July 1, 2010. Renumbered from Title 8, § 168 by Laws 2010, c. 58, § 33, eff. July 1, 2010.

§36-7109. Administration of act - Rules and regulations.

The Perpetual Care Fund Act shall be administered by the Insurance Commissioner. The Commissioner is authorized to promulgate reasonable rules and regulations concerning the keeping and inspection of records, the filing of contracts and reports, and all other matters concerning the orderly administration and implementation of the Perpetual Care Fund Act.

Added by Laws 1993, c. 218, § 5, eff. Sept. 1, 1993. Amended by Laws 2010, c. 58, § 8, eff. July 1, 2010. Renumbered from Title 8, § 168.1 by Laws 2010, c. 58, § 34, eff. July 1, 2010.

§36-7110. Violations - Punishment.

Any person, firm or corporation violating any of the provisions of the Perpetual Care Fund Act shall, upon conviction, be deemed guilty of a misdemeanor and shall be subject to a fine of not less than One Hundred Dollars (\$100.00) nor more than Two Thousand Five Hundred Dollars (\$2,500.00).

Added by Laws 1953, p. 17, § 9, emerg. eff. May 19, 1953. Amended by Laws 1993, c. 218, § 6, eff. Sept. 1, 1993. Renumbered from Title 8, § 169 by Laws 2010, c. 58, § 35, eff. July 1, 2010.

§36-7111. Fraudulent or intentional failure to honor contract.

It shall be unlawful for any owner or operator of a cemetery to accept money or anything of value under a contract entered into pursuant to the Perpetual Care Fund Act and fraudulently or intentionally fail or refuse to honor the contract providing for the improving, caring for, and embellishing of the burial lots, walks, drives, parks and other improvements in the cemetery.

In addition to other penalties authorized by law, this fraudulent or intentional failure or refusal to honor the contract with the consumer shall be a violation of the Oklahoma Consumer Protection Act pursuant to Sections 751 through 764.1 of Title 15 of the Oklahoma Statutes.

Added by Laws 1996, c. 8, § 1, eff. July 1, 1996. Amended by Laws 2010, c. 58, § 9, eff. July 1, 2010. Renumbered from Title 8, § 169.1 by Laws 2010, c. 58, § 36, eff. July 1, 2010.

§36-7112. Actions to recover payments and other monies - Censure and fine.

A. The Insurance Commissioner may initiate an action to recover payments required to be deposited to the State Insurance Commissioner Revolving Fund pursuant to the Perpetual Care Fund Act or to recover other monies received or disbursed in violation of the Perpetual Care Fund Act.

B. The Insurance Commissioner may, after an opportunity for hearing, censure an owner of a cemetery, levy a fine not to exceed One Thousand Dollars (\$1,000.00) for each occurrence, or any combination of the above for violation of any provision of the Perpetual Care Fund Act or any rules promulgated in accordance with the act.

Added by Laws 2000, c. 205, § 29, emerg. eff. May 17, 2000. Amended by Laws 2010, c. 58, § 10, eff. July 1, 2010. Renumbered from Title 8, § 170 by Laws 2010, c. 58, § 37, eff. July 1, 2010. Amended by Laws 2023, c. 213, § 2, eff. Nov. 1, 2023.

§36-7121. Cemetery Merchandise Trust Act.

Sections 7121 through 7135 of this title shall be known and may be cited as the "Cemetery Merchandise Trust Act". Added by Laws 1989, c. 297, § 17, eff. Nov. 1, 1989. Amended by Laws 2010, c. 58, § 11, eff. July 1, 2010. Renumbered from § 301 of Title 8 by Laws 2010, c. 58, § 38, eff. July 1, 2010. Amended by Laws 2013, c. 269, § 18, eff. Nov. 1, 2013.

§36-7122. Definitions.

As used in the Cemetery Merchandise Trust Act:

1. "Cemetery merchandise" means markers, memorials, vases, memorial vases, monuments, equipment, crypts, niches or outer enclosures. Cemetery merchandise shall not include the sale of lands or interests therein as grave lots or grave spaces; burial or interment rights; and delivered or installed crypts, niches or outer enclosures;
2. "Purchase price" means the gross amount to be paid for cemetery merchandise under the provisions of a prepaid cemetery merchandise contract. Purchase price shall not include finance charges, sales tax, charges for real property interests or charges for credit life insurance;
3. "Prepaid cemetery merchandise contract" means any agreement for the sale of cemetery merchandise by an organization which requires payment of the purchase price, in whole or in part, prior to delivery of the cemetery merchandise, which agreement is entered into from and after November 1, 1989;
4. "Minimum funding requirement" means that portion of the purchase price equal to one hundred ten percent (110%) of the wholesale cost, plus delivery charges, of the cemetery merchandise covered in a prepaid cemetery merchandise contract;
5. "Organization" means any individual, firm, partnership, trust, corporation, association or entity. Organization shall not include state, county, municipal, township, rural community, religious, fraternal or nonprofit entities, free community burial grounds, county cemetery associations, Indian tribal cemeteries on tribal land and charitable or eleemosynary institutions operating cemeteries in this state;
6. "Outer enclosure" means a grave liner, grave box, or grave vault;
7. "Lawn crypt" means a subsurface permanent outer enclosure installed before need in multiple units for the purpose of interring human remains;
8. "Financial institution" means a federally insured bank, trust company, or savings and loan association which is authorized to do business in this state;
9. "Commissioner" or "Insurance Commissioner" means the Insurance Commissioner of the State of Oklahoma; and

10. "Wholesale cost" means an amount determined on the basis of such standard quotations and price lists as are published by the vendor of the cemetery merchandise, without regard to any discounts that may be available to the organization.

Added by Laws 1989, c. 297, § 18, eff. Nov. 1, 1989. Amended by Laws 1993, c. 218, § 7, eff. Sept. 1, 1993; Laws 1994, c. 98, § 1, eff. Sept. 1, 1994; Laws 1995, c. 82, § 4, eff. Nov. 1, 1995; Laws 2009, c. 3, § 5, eff. July 1, 2009; Laws 2010, c. 58, § 12, eff. July 1, 2010. Renumbered from Title 8, § 302 by Laws 2010, c. 58, § 39, eff. July 1, 2010.

§36-7123. Permit required - Contracts in violation of act.

A. Any organization which shall accept money or anything of value for cemetery merchandise pursuant to a prepaid cemetery merchandise contract shall first obtain a permit from the Insurance Commissioner authorizing the transaction of this type of business before entering into the contract. It shall be unlawful to sell any prepaid cemetery merchandise unless the organization holds a valid, current permit at the time the contract is made. The organization shall not be entitled to enforce a contract made in violation of the Cemetery Merchandise Trust Act, but the purchaser, or the heirs or legal representative of the purchaser, shall be entitled to recover triple the amounts paid to the organization with interest thereon at the rate of six percent (6%) per annum under any contract made in violation of this act.

B. An organization with any prepaid cemetery merchandise contracts subject to the provisions of the Cemetery Merchandise Trust Act shall apply for, and obtain, approval of the Commissioner before transferring or conveying in any manner the cemetery, its obligations or both the cemetery and its obligations under the prepaid cemetery merchandise contracts. The application shall be accompanied by a fee equal to that required under Section 7125 of this title and shall include such information as the Commissioner may prescribe. The Commissioner shall not approve any such transfer or conveyance until the applicant has provided sufficient evidence that a cemetery merchandise trust fund equal to the minimum funding requirement is maintained pursuant to Section 7126 of this title or the applicant has obtained a surety bond pursuant to the provisions of Section 7127 of this title.

Added by Laws 1989, c. 297, § 19, eff. Nov. 1, 1989. Amended by Laws 1995, c. 82, § 5, eff. Nov. 1, 1995; Laws 2009, c. 3, § 6, eff. July 1, 2009; Laws 2010, c. 58, § 13, eff. July 1, 2010. Renumbered from § 303 of Title 8 by Laws 2010, c. 58, § 40, eff. July 1, 2010. Amended by Laws 2013, c. 269, § 19, eff. Nov. 1, 2013.

§36-7124. Administration of act - Appeals - Exemption for prepaid plans.

A. The Cemetery Merchandise Trust Act, Sections 7121 through 7135 of this title, shall be administered by the Insurance Commissioner. The Commissioner is authorized to promulgate reasonable rules concerning the keeping and inspection of records, the filing of contracts and reports, investments of and handling of the trust funds, and all other matters concerning the orderly administration and implementation of the Cemetery Merchandise Trust Act. All prepaid cemetery merchandise contracts shall be in writing, and no contract form created after July 1, 2010, shall be used without first being submitted to, and approved by, the Commissioner.

B. An organization aggrieved by an action or order of the Commissioner may appeal the action or order to the Oklahoma Insurance Department in accordance with Article II of the Administrative Procedures Act.

C. The provisions of the Cemetery Merchandise Trust Act shall not be applicable to any organization that has obtained a permit pursuant to Section 6121 of this title if the organization is in compliance with the provisions of Sections 6121 through 6136.18 of this title with respect to items that are considered cemetery merchandise pursuant to the Cemetery Merchandise Trust Act.

D. Unless sold pursuant to a permit issued under Section 6121 of this title, no organization in Oklahoma may sell, in advance of actual need, the services of opening or closing a burial space, as defined in Section 7102 of this title, unless the organization deposits in trust no less than sixty-five percent (65%) of the principal amount of the services sold, or maintains a surety bond for the full principal amount of the services sold. Any contracts for services sold before July 1, 2010, remain enforceable by the purchaser against the seller.

Added by Laws 1989, c. 297, § 20, eff. Nov. 1, 1989. Amended by Laws 1993, c. 218, § 8, eff. Sept. 1, 1993; Laws 1995, c. 82, § 6, eff. Nov. 1, 1995; Laws 2003, c. 57, § 27, emerg. eff. April 10, 2003; Laws 2009, c. 3, § 7, eff. July 1, 2009; Laws 2010, c. 58, § 14, eff. July 1, 2010. Renumbered from § 304 of Title 8 by Laws 2010, c. 58, § 41, eff. July 1, 2010. Amended by Laws 2013, c. 269, § 20, eff. Nov. 1, 2013.

§36-7125. Application for permit - Cancellation of or refusal to issue or renew permit - Appeal.

A. Each organization desiring to accept money or anything of value for prepaid cemetery merchandise shall file an application for a permit with the Insurance Commissioner, and shall at the time of filing the application pay one initial filing fee of Two Hundred Dollars (\$200.00). The Commissioner shall issue a permit upon the receipt of the application and payment of the filing fee, and upon making a finding that the applicant has complied with the rules as

may be established pursuant to the Cemetery Merchandise Trust Act by the Commissioner. All applications shall be signed by the organization requesting the permit, and shall contain a statement that the applicant will comply with all the requirements as established pursuant to the Cemetery Merchandise Trust Act. All permits shall expire on March 15 of the year following the year the permit is first issued, unless renewed. Permits shall be renewed for a period not to exceed the succeeding March 15 upon the payment of a renewal fee of Two Hundred Dollars (\$200.00). Late application for renewal of a permit shall require a fee of double the renewal fee. No application for renewal of a permit shall be accepted after April 15 of each year. Late applicants shall be required to reapply as if they were a new applicant, and pay an application fee equal to an amount that is double the renewal fee in addition to any fines that may have been imposed with respect to an expired permit.

B. The Commissioner may cancel a permit or refuse to issue a permit or refuse to issue a renewal of a permit for failure to comply with any provisions of the Cemetery Merchandise Trust Act or any rules promulgated thereto by the Commissioner, after reasonable notice to the permittee and opportunity for hearing before the Commissioner in accordance with Article II of the Administrative Procedures Act.

C. No organization shall be entitled to a new permit after cancellation, or refusal by the Commissioner to renew a permit, but shall thereafter be issued a new permit upon satisfactory proof of compliance with the Cemetery Merchandise Trust Act.

D. Any person or organization aggrieved by the actions of the Commissioner may appeal therefrom to the Oklahoma Insurance Department as provided by the Administrative Procedures Act. Added by Laws 1989, c. 297, § 21, eff. Nov. 1, 1989. Amended by Laws 1995, c. 82, § 7, eff. Nov. 1, 1995; Laws 2000, c. 205, § 30, emerg. eff. May 17, 2000; Laws 2008, c. 275, § 9, eff. July 1, 2008; Laws 2010, c. 58, § 15, eff. July 1, 2010. Renumbered from § 305 of Title 8 by Laws 2010, c. 58, § 42, eff. July 1, 2010. Amended by Laws 2013, c. 269, § 21, eff. Nov. 1, 2013.

§36-7126. Establishment and maintenance of cemetery merchandise trust funds

A. Each organization shall establish and maintain a cemetery merchandise trust fund with a financial institution having trust powers. A cemetery merchandise trust fund shall at all times be in the custody of a financial institution. Any cemetery merchandise trust funds may be invested, reinvested, exchanged, retained, sold and managed as a part of common trust funds in the manner provided in the Oklahoma Trust Act, Sections 175.1 through 175.57 of Title 60 of the Oklahoma Statutes, and any amendments thereto. A copy of each contract or a written notice containing all relevant

information regarding the prepaid cemetery merchandise contracts for which deposits are made shall be furnished to the financial institution. The financial institution shall serve as trustee for the purposes of the Cemetery Merchandise Trust Act.

B. Deposits to a cemetery merchandise trust fund shall be carried in the name of the organization and the amounts deposited therein may be commingled. Provided, however, the accounting records shall establish a separate account for each prepaid cemetery merchandise contract and shall show the amounts deposited, and the income or loss accruing thereon, with respect to each prepaid cemetery merchandise contract. The trustee shall reimburse the organization for all income taxes and costs incurred with respect to the operation of the fund, and the trustee shall be reimbursed from the earnings of the fund for all reasonable costs incurred in serving as trustee, including a reasonable fee for its services. The taxes and costs shall be paid from earnings for the fund prior to the allocation of earnings to the individual accounts.

C. An organization entering into a prepaid cemetery merchandise contract shall be entitled to retain all of the purchase price under the prepaid cemetery merchandise contract until it has received an amount equal to thirty-five percent (35%) of the purchase price of the cemetery merchandise sold in a prepaid cemetery merchandise contract.

D. After an organization has received the amount it is entitled to receive, in accordance with subsection C of this section, all payments of the purchase price to the organization pursuant to a prepaid cemetery merchandise contract shall be deposited by the organization in a cemetery merchandise trust fund until such time as the requirements of subsection E of this section have been satisfied or delivery is made of the cemetery merchandise, or until an amount satisfying the minimum funding requirement has been deposited. Thereafter, all payments of the purchase price in excess of the minimum funding requirement may be retained by the organization. Deposits shall be made within ten (10) business days after the end of the month in which such deposits are received by the organization.

E. Annually, as of December 31 of each year, each organization shall determine the wholesale cost for all cemetery merchandise covered by a prepaid cemetery merchandise contract for which funds are then held in a cemetery merchandise trust or in an individual merchandise account. If the amount held with respect to a prepaid cemetery merchandise contract exceeds the minimum funding required, the excess shall be paid by the trustee of the cemetery merchandise trust to the organization. In such event, no further deposit shall be required with respect to the prepaid cemetery merchandise contract until such time as the amount held no longer exceeds the minimum funding requirement. If the minimum funding requirement is

not satisfied, no amount shall be paid to or withdrawn by the organization and the organization shall continue or shall resume, as the case may be, making the deposits required by subsection D of this section.

F. No part of the monies required to be held in a cemetery merchandise trust fund pursuant to the provisions of the Cemetery Merchandise Trust Act shall ever be used for any other purpose other than investment as authorized by this section until delivery of the cemetery merchandise is made.

G. Delivery of cemetery merchandise for the purposes of this subsection may be accomplished in one of the following ways:

1. Actual and physical delivery of the cemetery merchandise to the purchaser;

2. Physical attachment of the cemetery merchandise to realty or cemetery space owned by the purchaser;

3. Certification by an approved manufacturer to the purchaser that the organization has paid the wholesale price of the cemetery merchandise and that the cemetery merchandise shall be delivered upon request of the purchaser;

4. Written notification to the purchaser by the organization that the cemetery merchandise is in the possession of the organization and may be removed by the purchaser upon full payment for the cemetery merchandise; and

5. When construction or permanent installation of the cemetery merchandise has been completed, with respect to cemetery merchandise which is affixed to realty.

H. Upon delivery of the cemetery merchandise pursuant to a prepaid cemetery merchandise trust contract, the organization shall present the trustee with a verified statement that delivery has been made, and upon the presentation, the trustee shall pay to the organization the amount of any funds held in trust with respect to the cemetery merchandise delivered and no further deposits shall be made with respect to the cemetery merchandise.

I. Should the buyer move to a community in which the cemetery does not accept transfers of outer enclosures from the cemetery which the buyer has entered into a cemetery merchandise contract, the selling organization will refund sixty-five percent (65%) of the retail price plus interest equal to the annual interest computed from the date that the contract was paid in full based on the passbook interest rate of the financial institution at the time that the refund is requested.

Added by Laws 1989, c. 297, § 22, eff. Nov. 1, 1989. Amended by Laws 1993, c. 218, § 9, eff. Sept. 1, 1993; Laws 1995, c. 82, § 8, eff. Nov. 1, 1995; Laws 2010, c. 58, § 16, eff. July 1, 2010. Renumbered from Title 8, § 306 by Laws 2010, c. 58, § 43, eff. July 1, 2010; Amended by Laws 2016, c. 118, § 7, eff. Nov. 1, 2016.

§36-7127. Surety bond in lieu of trust requirement.

A. As an alternative to the trust requirements of Section 7126 of this title, an organization may purchase a surety bond in an amount not less than the minimum funding requirement.

B. The surety bond shall be made payable to the State of Oklahoma for the benefit of the Insurance Commissioner and all purchasers of prepaid cemetery merchandise. The bond shall be approved by the Commissioner.

C. The Commissioner may establish by rule the requirements and guidelines for the surety bonds required pursuant to this section.

D. A surety bond maintained under the provisions of this section or Section 7124 of this title may be cancelled or terminated by the surety only by providing notice to the Commissioner, no later than ninety (90) days before the effective date of the cancellation or termination. Notwithstanding the cancellation, termination, or expiration of a bond maintained under this section or Section 7124 of this title, the surety shall remain liable for obligations arising during the term of the bond and prior to the termination, cancellation or expiration.

Added by Laws 1989, c. 297, § 23, eff. Nov. 1, 1989. Amended by Laws 1995, c. 82, § 9, eff. Nov. 1, 1995; Laws 2009, c. 3, § 8, eff. July 1, 2009; Laws 2010, c. 58, § 17, eff. July 1, 2010. Renumbered from § 307 of Title 8 by Laws 2010, c. 58, § 44, eff. July 1, 2010. Amended by Laws 2013, c. 269, § 22, eff. Nov. 1, 2013.

§36-7128. Annual report - Filing fee - Failure to file.

Each organization shall file an annual report with the Insurance Commissioner on or before March 15 of each year in a form as the Commissioner may require, showing the name of the financial institution holding the cemetery merchandise trust fund and the amount of the trust fund under each contract on the preceding December 31, and also showing the method of determination of the wholesale costs made pursuant to Section 7126 of this title. The total required deposits to the cemetery merchandise trust fund during the year shall also be reported. Each cemetery is responsible for maintaining satisfactory books and records, which will adequately justify all information contained in the annual report required by this section. Any organization which has discontinued the sale of prepaid cemetery merchandise, but which still has funds deposited in a cemetery merchandise trust fund or surety, shall not be required to obtain a renewal of its permit, but it shall continue to make annual reports to the Commissioner until all the funds have been disbursed pursuant to the Cemetery Merchandise Trust Act. A filing fee of Two Hundred Dollars (\$200.00) shall accompany each report. If any officer of any organization fails or refuses to file an annual report, or fails or refuses to cause it to be filed within thirty (30) days after the

organization has been notified by the Commissioner that the report is due and has not been received, the officer shall be guilty of a misdemeanor and shall be punished as prescribed in Section 7134 of this title.

Added by Laws 1989, c. 297, § 24, eff. Nov. 1, 1989. Amended by Laws 1993, c. 218, § 10, eff. Sept. 1, 1993; Laws 1995, c. 82, § 10, eff. Nov. 1, 1995; Laws 2000, c. 205, § 31, emerg. eff. May 17, 2000; Laws 2010, c. 58, § 18, eff. July 1, 2010. Renumbered from § 308 of Title 8 by Laws 2010, c. 58, § 45, eff. July 1, 2010. Amended by Laws 2013, c. 269, § 23, eff. Nov. 1, 2013.

§36-7129. Examination of wholesale costs.

The Insurance Commissioner may examine each organization so as to approve the determination by the organization of the wholesale costs made pursuant to Section 7126 of this title. The examination shall be conducted pursuant to Sections 309.1 through 309.7 of Title 36 of this title and the cost of the examination shall be paid by the cemetery owner. The cost of the examination shall be billed directly to the cemetery owner by the examiner.

Added by Laws 1989, c. 297, § 25, eff. Nov. 1, 1989. Amended by Laws 1995, c. 82, § 11, eff. Nov. 1, 1995; Laws 2010, c. 58, § 19, eff. July 1, 2010. Renumbered from § 309 of Title 8 by Laws 2010, c. 58, § 46, eff. July 1, 2010. Amended by Laws 2013, c. 269, § 24, eff. Nov. 1, 2013.

§36-7130. Redeposit of improperly withdrawn monies.

In the event the Insurance Commissioner determines that monies have been improperly paid by the trustee to the organization during the period covered by the examination, the Commissioner shall order the organization to redeposit to the trust the monies improperly withdrawn within sixty (60) days.

Added by Laws 1989, c. 297, § 26, eff. Nov. 1, 1989. Amended by Laws 1995, c. 82, § 12, eff. Nov. 1, 1995; Laws 2010, c. 58, § 20, eff. July 1, 2010. Renumbered from Title 8, § 310 by Laws 2010, c. 58, § 47, eff. July 1, 2010.

§36-7131. Attorney General - Action to recover payments - Penalties.

A. The Insurance Commissioner, may, after notice and an opportunity for hearing, initiate an action to recover payments required to be redeposited to the cemetery merchandise trust pursuant to the Cemetery Merchandise Trust Act or to recover other monies received or disbursed in violation of the Cemetery Merchandise Trust Act.

B. The Commissioner may, after an opportunity for hearing, censure a permittee or may suspend or revoke a permit for violation of any provision of the Cemetery Merchandise Trust Act. In addition

to, or in lieu of, any censure, suspension or revocation, a permittee may be subject to a civil penalty of not less than One Hundred Dollars (\$100.00) nor more than One Thousand Dollars (\$1,000.00) per occurrence or violation.

Added by Laws 1989, c. 297, § 27, eff. Nov. 1, 1989. Amended by Laws 1995, c. 82, § 13, eff. Nov. 1, 1995; Laws 2010, c. 58, § 21, eff. July 1, 2010. Renumbered from Title 8, § 311 by Laws 2010, c. 58, § 48, eff. July 1, 2010.

§36-7132. Execution, seizure, appropriation or application of certain funds prohibited.

In the absence of fraud, all funds held in a cemetery merchandise contract shall not be subject to attachment, garnishment or other legal process, or be seized, taken, appropriated or applied to pay any debt or liability of the organization, purchaser or beneficiary, by any legal or equitable process or by operation of law.

Added by Laws 1989, c. 297, § 25, eff. Nov. 1, 1989. Renumbered from Title 8, § 312 by Laws 2010, c. 58, § 49, eff. July 1, 2010.

§36-7133. Failure to assist examination of records - Application for receivership.

Whenever any officer of any organization refuses to submit the books, records, papers and instruments of an organization to the examination and inspection of the assistants or examiners of the Insurance Commissioner, or refuses or neglects to establish or maintain a cemetery merchandise trust fund in accordance with the requirements of the Cemetery Merchandise Trust Act within ninety (90) days after a written demand to establish or maintain a cemetery merchandise trust fund is made by the Commissioner, or in any manner obstructs or interferes with the examination of its cemetery merchandise trust fund, or refuses to be examined on oath concerning any of the affairs of its cemetery merchandise trust fund, the Commissioner may make application for receivership in the manner of a domestic insurer pursuant to Sections 1901 through 1920 of Title 36 of the Oklahoma Statutes.

Added by Laws 1989, c. 297, § 29, eff. Nov. 1, 1989. Amended by Laws 1995, c. 82, § 14, eff. Nov. 1, 1995; Laws 2010, c. 58, § 22, eff. July 1, 2010. Renumbered from Title 8, § 313 by Laws 2010, c. 58, § 50, eff. July 1, 2010.

§36-7134. Violations - Penalties.

Any organization, or its officers or directors, which violate any provision of the Cemetery Merchandise Trust Act shall, upon conviction, be deemed guilty of a misdemeanor and shall be subject to a fine of not less than One Hundred Dollars (\$100.00) nor more than Two Thousand Five Hundred Dollars (\$2,500.00).

Added by Laws 1989, c. 297, § 25, eff. Nov. 1, 1989. Amended by Laws 2010, c. 58, § 23, eff. July 1, 2010. Renumbered from Title 8, § 315 by Laws 2010, c. 58, § 51, eff. July 1, 2010.

§36-7135. State Insurance Commissioner Revolving Fund.

Upon the effective date of this act, all monies received by the State Banking Commissioner pursuant to the Cemetery Merchandise Trust Act and all monies deposited in the Cemetery Merchandise Trust Act Revolving Fund and any other monies as required by law shall be transferred to the State Treasury and deposited into the State Insurance Commissioner Revolving Fund provided for in Section 307.3 of Title 36 of the Oklahoma Statutes. Monies received after the effective date of this act pursuant to the Cemetery Merchandise Trust Act shall be deposited into the State Insurance Commissioner Revolving Fund. Monies in the fund may be expended for expenses incurred in administering and enforcing the Cemetery Merchandise Trust Act and the Perpetual Care Fund Act.

Added by Laws 1989, c. 297, § 32, eff. Nov. 1, 1989. Amended by Laws 1993, c. 218, § 11, eff. Sept. 1, 1993; Laws 1995, c. 82, § 16, eff. Nov. 1, 1995; Laws 2010, c. 58, § 24, eff. July 1, 2010. Renumbered from Title 8, § 316 by Laws 2010, c. 58, § 52, eff. July 1, 2010.

§36-7201. Definitions.

As used in this act:

1. "Access payments" means an amount paid to the Insurance Commissioner based upon a percentage of claims paid by a health carrier to be used to fund the state's Medicaid program and make full use of any federal matching funds available to the state;

2. "Claims paid" means all payments made by a health carrier for health and medical services for residents of this state.

"Claims paid" shall not include:

- a. claims-related expenses and general administrative expenses,
- b. payments made to qualifying providers under a "pay-for-performance" or other incentive compensation arrangement if the payments are not reflected in the processing of claims submitted for services rendered to specific covered individuals,
- c. claims paid by health carriers with respect to accidental injury, specified disease, hospital indemnity, dental, vision, disability income, long-term care, Medicare supplement or other limited benefit health insurance, except claims paid for dental services covered under a medical policy,
- d. claims paid for services rendered to nonresidents of this state,

- e. claims paid under retiree health benefit plans that are separate from and not included within benefit plans for existing employees,
 - f. claims paid by an employee benefit excess insurance carrier that have been counted by a third-party administrator for determining an access payment,
 - g. claims paid for services rendered to a person covered under a benefit plan for federal employees,
 - h. claims paid for services rendered outside of this state to a person who is a resident of this state, and
 - i. claims paid pursuant to Medicare or Medicaid;
3. "Claims-related expenses" means:
- a. payments for utilization review, care management, disease management, risk assessment and similar administrative services intended to reduce the claims paid for health and medical services rendered to cover individuals for the purposes of attempting to ensure that needed services are delivered in an efficacious manner or by helping to maintain or improve the health of a covered individual, and
 - b. payments made to or by organized groups of providers of health and medical services in accordance with managed care risk arrangements or network access agreements that are unrelated to the provision of services to specific covered individuals;
4. "Health and medical services" means, but is not limited to:
- a. any services included in the furnishing of medical care,
 - b. dental care to the extent covered under a medical insurance policy,
 - c. pharmaceutical benefits or hospitalization, including, but not limited to, services provided in a hospital or other medical facility,
 - d. ancillary services, including, but not limited to, ambulatory services,
 - e. physician and other practitioner services, including, but not limited to, services provided by an assistant to a physician, nurse practitioner or midwife, and
 - f. behavioral health services, including, but not limited to, mental health and substance abuse services;
5. "Health carrier" means any entity or insurer authorized to provide health insurance or health benefits pursuant to the laws of this state and any entity or person engaged in the business of making contracts of accident or health insurance. "Health carrier" includes, but is not limited to:

- a. third-party administrators as provided for in Sections 1441 through 1452 of Title 36 of the Oklahoma Statutes,
- b. health maintenance organizations as provided for in Sections 6901 through 6936 of Title 36 of the Oklahoma Statutes,
- c. self-insured employer welfare arrangements,
- d. excess carriers,
- e. stop loss carriers,
- f. multiple employer welfare arrangements (MEWA) as provided for in Sections 633 through 650 of Title 36 of the Oklahoma Statutes,
- g. professional employer organizations (PEO), and
- h. the Oklahoma State and Education Employees Group Insurance Board (OSEEGIB); and

6. "Insurance Commissioner" or "Commissioner" means the Oklahoma Insurance Commissioner.

Added by Laws 2010, c. 300, § 1.

NOTE: Editorially renumbered from § 7101 of this title to avoid duplication in numbering.

§36-7202. Health Carrier Access Payment Revolving Fund.

A. There is hereby created a mechanism of funding through health carrier access payments, as defined in Section 7201 of this title, in order to stabilize the state's Medicaid program.

B. There is hereby created in the State Treasury a revolving fund for the Oklahoma Health Care Authority to be designated the "Health Carrier Access Payment Revolving Fund". The revolving fund shall be used to fund the state's Medicaid program and make full use of any federal matching funds available to the state.

1. The revolving fund shall consist of all monies collected and received by the Insurance Commissioner pursuant to Sections 7203 and 7204 of this title, which shall be deposited by the Insurance Commissioner into the revolving fund, as well as interest attributable to investment of money in the fund.

2. The revolving fund shall be a continuing fund, not subject to fiscal year limitations. All monies accruing to the credit of said fund are hereby appropriated and may be budgeted and expended by the Oklahoma Health Care Authority. Expenditures from the revolving fund shall be made pursuant to the laws of this state and the statutes relating to the state's Medicaid program. Expenditures from the revolving fund shall be made upon warrants issued by the State Treasurer, based on claims filed as prescribed by law with the Director of the Office of Management and Enterprise Services for approval and payment.

C. All monies collected under Sections 7203 and 7204 of this title shall be used and expended by the Oklahoma Health Care

Authority for the support of the state's Medicaid program and make full use of any federal matching funds available to the state.

D. The Oklahoma Health Care Authority is hereby authorized to transfer funds from the Health Carrier Access Payment Revolving Fund to the 340 CMIA Programs Disbursing Fund administered by the Oklahoma Health Care Authority for the purpose of carrying out the provisions of this act.

E. No monies collected from health carriers as access payments shall be expended for any wage or salary of any employee of any state agency and shall not provide any general or administrative funding for the state or any of its agencies, except for reasonable expenses incurred by the Insurance Commissioner for the express purpose of collecting the funds and by the Oklahoma Health Care Authority for the express purposes and administration of the fund. Added by Laws 2010, c. 300, § 2. Amended by Laws 2012, c. 304, § 124.

NOTE: Editorially renumbered from § 7102 of this title to avoid duplication in numbering.

§36-7203. Access payment on paid claims.

A. From the effective date of this act until January 1, 2015, all health carriers shall pay to the Insurance Commissioner an access payment of one percent (1.0%) on all claims paid.

B. If a health carrier is contractually entitled to withhold certain amounts from payments due to providers of health and medical services for the purpose of ensuring that providers fulfill any financial obligations under a managed care risk arrangement, the full amounts due to the providers before the application of the contractual withholdings shall be reflected in the calculation of claims paid.

Added by Laws 2010, c. 300, § 3.

NOTE: Editorially renumbered from § 7103 of this title to avoid duplication in numbering.

§36-7204. Payment deadlines.

A. Except as provided in subsection B of this section, the access payments required to be paid by health carriers in Section 3 of this act shall be due and reported to the Insurance Commissioner on claims paid and incurred beginning July 1, 2010.

B. The access payments required in Section 3 of this act by a health carrier that is a third-party administrator or a self-insured employer shall be reported and paid on the basis of claims incurred and paid beginning July 1, 2010.

C. Access payments shall be made monthly to the Insurance Commissioner and are due thirty (30) days after the end of each month, except that access payments for third-party administrators

for groups of fifty or fewer members may be made annually not less than sixty (60) days after the close of the plan year.

D. All monies collected by the Insurance Commissioner pursuant to this act shall be paid into the State Treasury weekly and transferred monthly to the Health Carrier Access Payment Revolving Fund created in Section 2 of this act.

E. The Insurance Commissioner may refuse to renew, suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any health carrier failing to pay an access payment. In addition to failing to renew, suspension or revocation of the certificate of authority, the Insurance Commissioner may assess civil penalties in accordance with Section 619 of Title 36 of the Oklahoma Statutes against any health carrier failing to pay an access payment or may take any other enforcement action authorized by the Oklahoma Insurance Code to collect any unpaid access payments.

F. Reasonable attorney fees shall be awarded to the Insurance Commissioner if judicial action is necessary for the enforcement of this act. Attorney fees shall be based upon those prevailing in the community. Attorney fees collected by the Insurance Commissioner without the assistance of the Attorney General shall be credited to the State Insurance Commissioner Revolving Fund.

G. The Insurance Commissioner shall promulgate rules and the procedures necessary for the implementation and administration of this act.

Added by Laws 2010, c. 300, § 4.

NOTE: Editorially renumbered from § 7104 of this title to avoid duplication in numbering.

§36-7301. Dental plan fee regulation - Appeals procedures.

A. No contract between a dental plan of a health benefit plan and a dentist for the provision of services to patients may require that a dentist provide services to its subscribers at a fee set by the health benefit plan unless the services are covered services under the applicable subscriber agreement.

B. As used in this section:

1. "Covered services" means services reimbursable under the applicable subscriber agreement, subject to the contractual limitations on subscriber benefits as may apply, including, for example, deductibles, waiting period or frequency limitations;

2. "Dental plan" means and shall include any policy of insurance which is issued by a health benefit plan which provides for coverage of dental services not in connection with a medical plan; and

3. "Health benefit plan" means any plan or arrangement as defined in subsection C of Section 6060.4 of this title or any

dental service corporation authorized pursuant to Section 2671 of this title.

C. A health benefit plan or dental plan shall establish and maintain appeal procedures for any claim by a dentist or a subscriber that is denied based on lack of medical necessity. Any such denial shall be based upon a determination by a dentist who holds a nonrestricted license in the United States. Any written communication to a dentist that includes or pertains to a denial of benefits for all or part of a claim on the basis of a lack of medical necessity shall include the identifier and license number together with state of issuance, and a contact telephone number of the licensed dentist making the adverse determination. The dentist who reviewed the claim shall only be contacted at the telephone number provided in the written communication about the denial during business hours.

Added by Laws 2010, c. 146, § 1, eff. Nov. 1, 2010. Amended by Laws 2013, c. 69, § 1, eff. Nov. 1, 2013.

NOTE: Editorially renumbered from Title 36, § 7101 to avoid a duplication in numbering.

§36-7302. Dental insurance plans - Contracting entity requirements

A. As used in this section:

1. "Contracting entity" means any person or entity that is engaged in the act of contracting with providers for the delivery of dental services or the selling or assigning of dental plans to other dental care entities;

2. "Identify" means providing in writing, by email or otherwise, to the participating provider the name, address and telephone number, to the extent possible, for any third party to which the contracting entity has granted access to the dental services of the participating provider;

3. "Network plan" means dental plans offered by a health insurance issuer under which the financing and delivery of dental services are provided in whole or in part through a defined set of participating providers under contract with the health insurance issuer;

4. "Participating provider" means a provider who, under a contract with a contracting entity, has agreed to provide dental services with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly, from the contracting entity; and

5. "Provider" means any person licensed by the Board of Dentistry pursuant to the provisions of Section 328.21 of Title 59 of the Oklahoma Statutes.

B. A contracting entity shall not sell, assign or otherwise grant access to the dental services of a participating provider under any health care contract unless expressly authorized by the

health care contract. The health care contract shall specifically provide that one purpose of the contract is the selling, assigning or giving the contracting entity rights to the services of the participating provider, including network plans.

C. Upon entering a contract with a participating provider and upon request by a participating provider, a contracting entity shall properly identify any third party that has been granted access to the dental services of the participating provider.

D. A contracting entity that sells, assigns or otherwise grants access to the dental services of a participating provider shall maintain an Internet website or a toll-free telephone number through which the participating provider may obtain information which identifies the insurance carrier to be used to reimburse the participating provider for the covered dental services.

E. A contracting entity that sells, assigns or otherwise grants access to a participating provider's dental services shall ensure that an explanation of benefits or remittance advice furnished to the participating provider that delivers dental services under the health care contract identifies the contractual source of any applicable discount.

F. All third parties that have contracted with a contracting entity to purchase, be assigned or otherwise be granted access to the participating provider's discounted rate shall comply with the participating provider's contract, including all requirements to encourage access to the participating provider, and pay the participating provider pursuant to the rates of payment and methodology set forth in that contract, unless otherwise agreed to by a participating provider.

G. A contracting entity is deemed in compliance with this section when the insured's identification card provides information which identifies the insurance carrier to be used to reimburse the participating provider for the covered dental services.

Added by Laws 2016, c. 126, § 1, eff. Nov. 1, 2016.

§36-7303. Prohibition on denial of claim in a prior authorization - Exceptions - Requirements.

A. For the purposes of this section, "prior authorization" means any predetermination, prior authorization, or similar authorization that is verifiable, whether through issuance of letter, facsimile, email, or similar means, indicating that a specific procedure is, or multiple procedures are, covered under the patient's dental plan and reimbursable at a specific amount, subject to applicable coinsurance and deductibles, and issued in response to a request submitted by a dentist using a format prescribed by the insurer.

B. A dental service contractor shall not deny any claim subsequently submitted for procedures specifically included in a

prior authorization unless at least one of the following circumstances applies for each procedure denied:

1. Benefit limitations such as annual maximums and frequency limitations not applicable at the time of the prior authorization are reached due to utilization subsequent to issuance of the prior authorization;

2. The documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized;

3. If, subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the condition of the patient occurs such that the prior authorized procedure would no longer be considered medically necessary, based on the prevailing standard of care;

4. If, subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the condition of the patient occurs such that the prior authorized procedure would at that time required disapproval pursuant to the terms and conditions for coverage under the plan of the patient in effect at the time the prior authorization was used; or

5. The denial of the dental service contractor was due to one of the following:

- a. another payor is responsible for payment,
- b. the dentist has already been paid for the procedures identified on the claim,
- c. the claim was submitted fraudulently or the prior authorization was based in whole or material part on erroneous information provided to the dental service contractor by the dentist, patient, or other person not related to the carrier, or
- d. the person receiving the procedure was not eligible to receive the procedure on the date of service and the dental service contractor did not know, and with the exercise of reasonable care could not have known, of their eligibility status.

C. A dental service contractor shall not require any information be submitted for a prior authorization request that would not be required for submission of a claim.

D. A dental service contractor shall issue a prior authorization within thirty (30) days of the date a request is submitted by a dentist.

E. The provisions of Section 7301 of Title 36 of the Oklahoma Statutes shall apply to any denial of a claim pursuant to subsection B of this section for a procedure included in a prior authorization.

F. The dental service contractor shall not recoup a claim solely due to a loss of coverage of a patient or ineligibility if, at the time of treatment, the contractor erroneously confirms

coverage and eligibility, but had sufficient information available to it indicating that the patient was no longer covered or was ineligible for coverage.

Added by Laws 2019, c. 437, § 1, eff. Nov. 1, 2019.

§36-7401. Stop-loss coverage - Minimum aggregate retention.

Any stop-loss insurance coverage issued by an insurer authorized to do business in this state that provides an aggregate retention benefit shall provide an aggregate retention of no less than one hundred ten percent (110%) of the expected claims. The Insurance Commissioner shall develop minimum disclosure standards that can be incorporated into a form that shall be utilized by insurers issuing stop-loss insurance coverage to small employers, as defined in Section 6512 of Title 36 of the Oklahoma Statutes, in Oklahoma. The minimum disclosure standards and form shall be promulgated by rule in accordance with the Administrative Procedures Act.

Added by Laws 2016, c. 247, § 1, eff. Nov. 1, 2016.

§36-7402. Evaluation of effect of limits on opioid prescriptions and claims and out-of-pocket costs - Report.

The Insurance Department shall evaluate the effect of the limits on prescriptions for opioid drugs established by this act on the claims paid by health insurance carriers and the out-of-pocket costs including copayments, coinsurance and deductibles paid by individual and group health insurance policyholders. On or before January 1, 2021, the Insurance Department shall submit a report on the evaluation, along with any recommended policy and regulatory options that will ensure costs for patients are not increased as a result of new prescribing limitations on the amounts of opioid drugs, to the standing committees of the Legislature having jurisdiction over health and human services matters and over insurance and financial services matters. The Insurance Commissioner may adopt reasonable rules and regulations for the implementation and administration of the provisions of this subsection.

Added by Laws 2019, c. 428, § 20, emerg. eff. May 21, 2019.