Independent Insurance Agents & Brokers of Louisiana

Frequently Requested
Louisiana Insurance Statutes

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Table of Contents

Producer Statutes

Producer Licensing	4
Producer of Record	17
Producer Compensation	19
Agency Fees	21
Agent Exclusive Use of Expirations	23
Agent E&O Statute of Limitations	25

Policy & Claims Statutes

Approval of Policy Forms	26
Approval of Rates	34
Use of Credit Information	46
Certificates of Insurance	49
Calendar Year Storm Deductibles	53

Consumer Protection Statutes

Claims & Bad Faith Settlement	54
Unfair Trade Practices	58
Valued Policy	69
Louisiana Insurance Guaranty Association	70

Cancellation & Nonrenewal

Automobile Cancellation	82
Homeowners Cancellation	88
Commercial Cancellation	91
Surplus Lines Cancellation	95

Please note that these materials are intended to be educational in nature, do not constitute a comprehensive representation of Louisiana statutes, and is not intended to provide legal advice. Please consult an attorney for any specific legal advice.

Workers Compensation

Covered Employees & Exemptions	96
Liability of Principal Contractors	103
Exclusive Remedy	104
Agent GSIF Insolvency Limitation	105

Surplus Lines

Surplus Lines Authorization	106
Surplus Lines Solvency Requirements	108
Surplus Lines “White List”	109
Surplus Lines Acknowledgement Form	111
Surplus Lines Tax	112

How to Find Louisiana Statutes 115

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Producer Licensing

§ 1543. License required

A. No person shall act as or hold himself out to be an insurance producer unless licensed by the Department of Insurance.

B. No insurance producer shall sell, solicit, make an application for, procure, negotiate for, or place for others, any policies for any lines of insurance as to which he is not then qualified and duly licensed in this state.

§ 1544. Exceptions to licensing; prohibitions

A. Nothing in this Subpart 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's, director's, or employee's activities are executive, administrative, managerial, clerical, or a combination of these, and are not the sale, solicitation, or negotiation of insurance;

(b) The officer's, director's, 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 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 employer's or association's 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 employer, association, 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 this 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 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.

(8) Employees of an insurer or of an insurance producer who respond to requests from existing policyholders on existing policies, provided that those employees are not directly compensated based on the volume of premiums that may result from these services, and provided those employees do not sell, solicit, or negotiate insurance.

C. (1) The Department of Insurance shall not grant, renew, reinstate, or permit to continue any license if the license is being or will be used by the applicant or licensee for the sole purpose of writing controlled business. For purposes of this Subpart, “controlled business” shall mean either of the following:

(a) Insurance written on the interests of the licensee or those of his immediate family or of his employer.

(b) Insurance covering himself or members of his immediate family, or a corporation, association, or partnership, or the officers, directors, substantial stockholders, partners, or employees of a corporation, association, or partnership, of which he or a member of his immediate family is an officer, director, substantial stockholder, partner, associate, or employee.

(2) Nothing in this Subsection shall apply to insurance written in connection with any credit transactions.

(3) Any license under this Subsection shall be deemed to have been, or intended to be, used for the purpose of writing controlled business, if the Department of Insurance determines that during any twelve-month period the aggregate commissions earned from the controlled business has exceeded twenty-five percent of the aggregate commissions earned on all business written by such applicant or licensee during the same period.

D. No person shall be licensed as an insurance producer, limited lines producer, surplus lines broker, or managing general agent in this state if they, or any person who owns directly or indirectly more than ten percent of the beneficial interest in a business entity applying for a license, are either a citizen of, resident of, domiciled in, or the commissioner determines that they or the beneficial owner maintain significant assets in, a country that the commissioner determines does not give full faith and credit to any judgment rendered by a court of this state or of the United States, or that the country does not have laws similar to those of this state for the discovery of assets of the insurer, seizure or sale of such assets, and execution of a judgment thereof.

§ 1546. Application for license

<Text of section effective January 1, 2010>

A. A person applying for a resident insurance producer license shall make application to the commissioner of insurance on the Uniform Application 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 commissioner shall find that the individual:

(1) Is at least eighteen years of age.

(2) Resides in the state or maintains his principal place of business in the state.

(3) Is not disqualified for having committed any act that is a ground for denial, suspension, or revocation set forth in R.S. 22:1554.

(4) Has completed a prelicensing course of study for the lines of authority for which the person has applied.

(5) Has paid the fees set forth in R.S. 22:821.

(6) Has successfully passed the examinations for the lines of authority for which the person has applied.

(7) When applicable, has the written consent of the commissioner of insurance pursuant to 18 U.S.C. 1033, or any successor statute regulating crimes by or affecting persons engaged in the business of insurance whose activities affect interstate commerce.

B. (1)(a) A business entity acting as an insurance producer is required to obtain an insurance producer license. Every member, partner, officer, director, stockholder, and employee of the business entity personally engaged in this state in soliciting or negotiating policies of insurance shall be registered with the Department of Insurance under such business entity's license, and each such member, partner, officer, director, stockholder, or employee shall also qualify as an individual licensee for any line of insurance the business entity is licensed to transact. Licensing of any limited liability company or limited liability partnership as an insurance producer is subject to prior approval of the commissioner of insurance.

(b) The business entity licensee shall within thirty days notify the commissioner of insurance of any change of status of an individual who is registered under the business entity license.

(c) Any business entity operating at more than one location shall notify the commissioner of insurance of each permanent branch location address within thirty days from the date of the opening of the new location. There must be at least one individual licensed insurance producer registered with the Department of Insurance for each branch location.

(d) Any business entity which fails to comply with this Subsection shall be subjected to a fine of one hundred dollars for each violation. Any entity against which a fine has been levied shall be given due notice of such action. Upon receipt of this notice, the entity may apply for and shall be entitled to a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

(2) Application shall be made using the Uniform Business Entity Application. Before approving the application, the commissioner of insurance shall find that:

(a) The business entity has paid the fees set forth in R.S. 22:821.

(b) The business entity has designated one or more licensed individual producers responsible for the business entity's compliance with the insurance laws, rules, and regulations of this state.

<Par. (B)(3) effective until January 1, 2010>

(3) The Uniform Business Entity Application shall be accompanied by:

(a) If a corporation or a limited liability company, a current letter of good standing from the secretary of state's office, verification by the secretary of the corporation that the directors and officers were duly appointed or elected in accordance with the articles of incorporation and bylaws of the corporation, and an attestation by the president of the corporation disclosing the identity and percentage of ownership of all officers and directors, and of those persons who own ten percent or more of the owner applicant as that term is used in the Uniform Business Entity Application.

(b) If a partnership or a limited liability partnership, a current letter of registration from the secretary of state's office, verification by the appropriate partner that the partners listed on the application are duly named as partners in accordance with the partnership agreement, and a statement under oath verifying the percentage of interest and control of each partner in the partnership.

(c) If a bank chartered under the laws of this or any state, or of the United States, a current letter of good standing from its chartering authority, verification by the cashier or secretary of the bank that the directors and executive officers were duly appointed or elected in accordance with the articles and bylaws of the bank, and an attestation by the president of the bank disclosing the identity and percentage of ownership of the shareholders who own ten percent or more of the bank; such shareholders owning ten percent or more of the shares of the bank shall constitute the owners, and such executive officers shall constitute the officers, as those terms are used in the Uniform Business Entity Application.

(d) If an association or other business entity, such documentation as the commissioner of insurance may deem necessary and appropriate.

(3) Repealed by Acts 2009, No. 485, § 3, eff. Jan. 1, 2010.

(4) When completing the background information portion of the Uniform Business Entity Application pertaining to the disclosure of certain lawsuits or arbitration proceedings, corporations, banks, partnerships, or other business entities, and their executive officers and directors, shall disclose those proceedings occurring within the past five years which are considered to be material under generally accepted accounting principles for purposes of financial statement disclosure.

CHANGES IN LICENSING STATUS MUST BE REPORTED TO LDI WITHIN 30 DAYS

USING THE CHANGE OF RECORD FORM FOUND AT THE FOLLOWING LINK:

http://www.ldi.state.la.us/Documents/Licensing/Producer/changeofrecord.pdf

C. Any professional law corporation formed pursuant to R.S. 12:801 et seq., or any limited liability company, limited liability partnership, or partnership formed for the practice of law, as authorized by R.S. 37:213, may be licensed as a title insurance producer.

D. (1) The commissioner of insurance may require any documents deemed necessary to verify the information contained in an application.

(2) In order to make a determination of license eligibility, the commissioner of insurance may require fingerprints of applicants and submit the fingerprints and the fees required to perform the criminal history record checks to the Louisiana Bureau of Criminal Identification and Information for state and national criminal history record checks. The commissioner of insurance shall require a criminal history record check on each applicant in accordance with this Subpart. The commissioner of insurance shall require each applicant to submit a full set of fingerprints in order for the commissioner of insurance to obtain and receive National Criminal History Records from the FBI Criminal Justice Information Services Division.

(3) The commissioner of insurance may contract for the collection, transmission, and re-submission of fingerprints required under this Section. If the commissioner of insurance does so, the fee for collecting and transmitting fingerprints and the fee for the criminal history record check shall be payable directly to the contractor by the applicant. The commissioner of insurance may agree to a reasonable fingerprinting fee to be charged by the contractor.

(4) The commissioner of insurance shall treat and maintain an applicant's fingerprints and any criminal history record information obtained under this Section as confidential and shall apply security measures consistent with the Criminal Justice Information Services Division of the Federal Bureau of Investigation standards for the electronic storage of fingerprints and necessary identifying information and limit the use of records solely to the purposes authorized in this Section. The fingerprints and any criminal history record information shall be exempt from the public records law (R.S. 44:1 et seq.,) shall not be subject to subpoena, other than a subpoena issued in a criminal proceeding or investigation, and shall be confidential by law and privileged, and shall not be subject to discovery or admissible in evidence in any private civil action.

E. Each insurer that sells, solicits, or negotiates any form of limited line credit insurance shall provide to each individual whose duties will include selling, soliciting, or negotiating limited line credit insurance a program of instruction that may be approved by the commissioner of insurance.

F. Any license issued pursuant to an application claiming residency for licensing purposes, as defined herein, shall constitute an election of residency in the state, and shall be void if the licensee while maintaining a resident license also maintains a license in, or thereafter submits an application for a license in, any other state or other jurisdiction stating that the applicant is a resident of such other state or jurisdiction, or if the licensee ceases to be a resident of this state.

G. Except as authorized by R.S. 6:242, no bank, bank holding company, or any subsidiary or employee thereof shall be licensed as or engage in any insurance activity as an insurance producer. However, a bank which was engaged as an insurance producer on January 1, 1984, may continue to be so engaged. The commissioner shall license any qualified state or national bank, bank holding company, or any subsidiary or employee thereof to engage in any insurance or annuity activity as authorized by R.S. 6:242, as an insurance producer.

H. In addition to the authority conferred by Subsection G of this Section, or R.S. 6:242, a bank, bank holding company, or any subsidiary or employee thereof shall have and possess, and may exercise, such rights, powers, privileges, and immunities of a national bank or national bank branch engaged in insurance sales activities in this state.

PRE-2008 STATUTORY REFERENCES IN EDITORIAL NOTES
<Statutory references in italic and historical notes and notes of decisions written before 2008 conform to the Title 22 numbering scheme as it existed prior to the complete renumbering of Title 22 by Acts 2008, No. 415. For Title 22 provisions as renumbered in 2008, see the Disposition Table at the beginning of this volume.>

§ 1548. Nonresident licensing

A. Unless denied licensure pursuant to R.S. 22:1554, a nonresident person shall receive a nonresident producer license if:

(1) The person is currently licensed as a resident and in good standing in his or her home state.

(2) The person has submitted the proper request for licensure and has paid the fees required by R.S. 22:821.

(3) The person has submitted or transmitted to the commissioner of insurance the application for licensure that the person submitted to his or her home state, or in lieu of the same, a completed Uniform Application.

(4) The person's home state awards nonresident producer licenses to residents of this state on the same basis.

B. (1) The commissioner of insurance may verify the producer's licensing status through the producer database maintained by the National Association of Insurance Commissioners, its affiliates, or subsidiaries.

(2) Whenever, by the laws or regulations of any other state or jurisdiction, any limitation of rights and privileges, conditions precedent, or any other requirements are imposed upon residents of this state who are nonresident applicants or licensees of such other state or jurisdiction in addition to, or in excess of, those imposed on nonresidents under this Subpart, the same such requirements shall be imposed upon such residents of such other state or jurisdiction.

(3)(a) The commissioner of insurance shall not issue a license to any nonresident applicant until such applicant has filed forms approved by the commissioner which designate the commissioner as his true and lawful agent, 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 applicant's insurance business in this state. The designation shall constitute an agreement that such service of process has the same legal force and validity as personal service of process upon the person in the state.

(b) The service of process upon any such licensee in any action or proceeding in any court of competent jurisdiction may be made by a party serving the commissioner of insurance with appropriate copies thereof and the payment to him of a fee of twenty-five dollars, or as may be authorized by R.S. 22:821.

(c) The commissioner of insurance shall, within ten days of being served, forward a copy of such process by registered or certified mail, return receipt requested, to the

licensee at his last known address of record or principal place of business, and the commissioner shall maintain copies of all such processes so served upon him.

(4) The service of process upon any such licensee in any action or proceeding instituted by the commissioner of insurance under this Subpart shall be made by the commissioner by mailing such process by registered or certified mail, return receipt requested, to the licensee at his last known address of record or principal place of business.

C. 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 days of the change of legal residence. No fee or license application is required.

D. (1) Notwithstanding any other provision of this Subpart, an insurance producer licensed as a surplus lines broker in his home state shall receive a nonresident surplus lines broker license pursuant to Subsection A of this Section.

(2) Except as provided by Subsection A of this Section, nothing in this Section otherwise amends or supersedes any provision of R.S. 22:1902 et seq.

E. Notwithstanding any other provision of this Subpart, a person licensed as a limited line credit insurance or other type of limited lines producer in his home state shall receive a nonresident limited lines producer license, pursuant to Subsection A of this Section, granting the same scope of authority as granted under the license issued by the producer's home state. For the purposes of this Subsection, limited line insurance is any authority granted by the home state which restricts the authority of the licensee to less than the total authority prescribed in the associated major lines pursuant to R.S. 22:1547(A)(1) through (5).

§ 1557. Commissions

A. (1) An insurer or insurance producer shall not pay, directly or indirectly, any commission, service fee, brokerage, or other valuable consideration to any person or entity for selling, soliciting, or negotiating insurance in this state unless such person or entity holds a valid license as required by law.

(2) No person or business entity other than a person or business entity duly licensed by the Department of Insurance as an insurance producer shall accept any commission, service fee, brokerage, or other valuable consideration for selling, soliciting, or negotiating insurance in this state.

(3) 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 Subpart at the time of the sale, solicitation, or negotiation and was so

licensed at that time.

B. (1) No member of an insurance advisory committee of any state agency, board, commission, or of any political subdivision of this state, including but not limited to school boards, levee boards, deep water port commissions, deep water port, harbor and terminal districts, and the Louisiana Stadium and Exposition District, shall split, pass on, or share with any insurance producer or other person who is not a member of his own firm or corporation and is not a member of said insurance advisory committee, all or any portion of the commission derived by such committee from the purchase of insurance by such state agency, board, commission, or political subdivision of the state without express authorization by official action of such state agency, board, commission, or political subdivision of the state. Any insurance producer or other person who is not a member of such firm or corporation and is not a member of said insurance advisory committee who receives without authorization all or any portion of such commission shall also be in violation of this Subsection.

(2) Any violator of the provisions of this Subsection shall, upon conviction, be fined not less than one thousand dollars, nor more than five thousand dollars per violation, or imprisoned for not more than two years, or both.

(3) Any conviction for a violation of the provisions of this Subsection shall constitute grounds for suspension or revocation by the commissioner of insurance of the license of such insurance producer, in addition to those grounds of R.S. 22:1554.

§ 1562. Prohibited acts

A. (1) No insurer or insurance producer shall pay any money or commission or brokerage, or give or allow any valuable consideration or compensation to any person or business entity not duly licensed as an insurance producer, nor to an insurer not licensed to do business in this state, for or because of service rendered or performed in this state in selling, soliciting, negotiating, or effecting a contract of insurance on any property or risks, or insurable interests, or business activities located within or transacted within this state. The prohibition of this Subsection shall not apply with respect to any contract of reinsurance.

(2) The prohibition of this Subsection shall not apply to the distribution of profits to the owners of an insurance agency. The provisions of this Paragraph shall not apply to the Louisiana Workers' Compensation Corporation.

B. (1) Whoever violates this Section shall, upon conviction, be fined not less than two thousand dollars, nor more than fifty thousand dollars, or imprisoned with or without hard labor, for not more than three years, or both.

(2) Any conviction for violation of this Section shall constitute grounds for the immediate suspension or revocation by the commissioner of insurance of the license of such insurance producer to sell insurance, in addition to those grounds set forth in R.S. 22:1554.

C. (1) It shall be unlawful for any person or business entity, without conforming to the provisions of this Part, directly or indirectly, to represent himself or itself to be an insurance producer or limited lines producer, or to solicit, negotiate, or effect any contract of insurance or renewal thereof, or to attempt to effect the same on any property, or risk or insurable interests or business activities, located within or transacted within this state. This Subsection shall not apply to:

(a) The clerical duties of office employees not involved in soliciting insurance.

(b) Employees of insurance companies who solicit insurance only for or in conjunction with licensed insurance producers compensated on a commission basis.

(c) The collection of premiums by secretarial or clerical employees of a licensed insurance producer, or other person so authorized by a licensed insurance producer.

(d) Employees of insurance companies who do not solicit insurance but are authorized by their employer to sign policies of insurance.

(2) Wherever the commissioner of insurance determines that a violation of Paragraph (1) of this Subsection has occurred, whether that violation be intentional or not, the commissioner or his designee is hereby authorized to issue an order to cease and desist from the violations complained of, and the commissioner is hereby authorized to seek injunctive relief from the district court of the district in which the violation may have occurred or in any proper venue authorized under the Louisiana Code of Civil Procedure.

D. (1) No person licensed as, or representing himself to be, an insurance producer shall receive anything of value as premium payment or commission for an insurance policy rider, binder, or plan without making a bona fide application to an insurer for an insurance policy.

(2) No person licensed as, or representing himself to be, an insurance producer shall fail to account for or remit any premiums, monies, or properties belonging to another which come into the possession of the applicant in the course of doing insurance business, or improperly withholding, misappropriating, converting, or failing to timely remit any premiums, monies, or properties received in the course of doing insurance business, whether such premiums, monies, or properties belong to policyholders, insurers, beneficiaries, claimants, or others.

E. (1) It shall be unlawful for any insurance producer, directly or indirectly, to collect any insurance premium payment, or compensation, or to solicit, negotiate, effect, procure,

receive, or forward any contract of insurance or renewal thereof, in relation to any property or risk or insurable interest in this state, for any insurer not lawfully authorized to transact business in this state, or in any manner to aid or assist in any such transaction, except through licensed surplus lines brokers.

(2) Except as hereinafter provided in Paragraph (3) of this Subsection, any person or business entity shall be liable for the full amount of any loss sustained on any contract of insurance made by or through him or it, directly or indirectly, with any insurer not lawfully authorized to transact business in this state, and for any taxes which may become due under any law of this state by reason of such contract. For purposes of this Section, any surplus lines insurer which is approved by the commissioner shall be considered lawfully authorized to transact business in this state.

(3) Any licensed producer who writes a policy through a licensed surplus lines broker shall not be liable for any losses or taxes as provided for in this Section.

(4) Any person or business entity found to have violated this Subpart shall be deemed to have engaged in unfair trade practices and shall be subjected to the penalties provided herein. Additionally, any person found to have knowingly and intentionally violated any provisions of this Subsection shall be guilty of a felony and shall be subjected to a term of imprisonment, with or without hard labor, not to exceed five years, on each count, and each day on which a violation of this Subsection occurs shall be considered a separate violation.

F. It shall be unlawful for any producer to sign any policy of insurance endorsement in blank.

G. Repealed by Acts 2001, No. 1158, § 3.

H. No insurer, agent, or broker shall accept or process an application for coverage under a Medicare+Choice plan unless the following requirements are met:

(1) The Medicare enrollee or his authorized representative has signed the application for coverage.

(2) The Medicare enrollee is provided a written notice upon transfer from one approved Medicare+Choice plan to another stating that his coverage is being transferred. Such notice shall also state how the change in coverage will impact the Medicare enrollee's access to health care providers, including specifying any known change in health care providers available to provide care.

(3) The Medicare enrollee is provided a written notice upon plan cancellation of his current Medicare+Choice coverage that clearly states the date his coverage ends.

(4) The Medicare enrollee is notified of any known change in health care providers that may reasonably result from the action of the agent or broker.

§ 1563. Reporting of actions

A. An insurance producer shall report to the commissioner of insurance any administrative action taken against the producer in another jurisdiction or by another governmental agency in this state within thirty 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 days of a conviction in district court of an offense under R.S. 22:1554(A)(7), a producer shall report such conviction to the commissioner and provide a copy of the bill of information or indictment.

C. Without in any way limiting or affecting any other civil or criminal remedies or consequences, any person who intentionally withholds or intentionally fails to timely report information as required by this Section shall be guilty of violating R.S. 22:1554(A)(14).

Producer of Record

§ 1564. Producers of record

A. (1) Any insurer which issues or delivers a policy or contract of insurance pursuant to the application or request of a producer who is not authorized to represent said insurer as a producer shall be deemed to have authorized such producer as producer of record to act on the insurer's behalf. The payment to such a producer shall be payment to the insurer with all resultant obligations and duties.

(2) This Subsection establishes an agency relationship only for the matter of collection of premiums specifically referred to herein.

B. (1)(a) Any insurance company authorized to transact property, casualty, accident, or health insurance or bond business in this state or issuing or delivering property, casualty, accident, or health insurance, or bonds in this state shall recognize a producer of record when selected by the owner of the policy or the first-named insured if there are multiple-named insureds in writing. The insurer shall recognize the producer of record for purposes of providing quotations or proposals or writing such policies or bonds. The insurer shall retain the producer of record who wrote such policies or bonds for the full term of the contracts or until the renewal date or termination of the contracts, whichever occurs first. The insurer shall not change or remove such producer by any producer of record letter which may be secured by another producer for purposes of providing a quotation or proposal or for writing such policies or bonds during the term of such contracts until the renewal date of the contracts, unless the change or removal is requested by the owner of the policy or the first-named insured if there are multiple-named insureds under a particular contract. In such case, such owner or insured shall select the new producer of record.

(b) If the insurer receives a producer of record letter for an application, the insurer shall provide the producer of record with a quotation or proposal regardless of any other outstanding quotations or proposals. If the quotation or proposal is accepted by the insured, the insurer shall issue the policy with the designated producer of record. If the insurer receives a written request by the insured to change the producer of record on an application, the insurer shall give the initial producer of record written notice fifteen days in advance of the change or removal. If the insurer receives a request to change a producer of record on an application within fifteen days of the policy inception, the insurer shall provide the required fifteen-day notice; however, any required change of producer shall be effective on the inception date of the policy.

(c) If a change or removal of a producer is requested by an insured during a policy period, the insurer shall give the producer written notice fifteen days in advance of the change or removal. If the insurer receives a request to change a producer within the last fifteen days of the policy period, the insurer shall provide the required fifteen-day notice;

however, any required change of producer shall be effective on the inception date of the renewal policy.

(d) Property, casualty, and bond commissions shall be paid to the original producer of record at the policy inception for the full term of the policy, unless such policy is written for more than one year or is continuous until canceled, in which case commissions shall be paid to the new producer of record starting on the anniversary rating date when new rates take effect. Accident, health, or benefits commissions shall be paid to the current producer of record and shall change when the producer of record changes.

(2) Except as provided in Paragraph (1) of this Subsection, no insurer or producer shall cancel and rewrite any such contracts during the term of such contract or until the renewal date of the contract, whichever occurs first, which would change the producer of record.

(3) This Subsection shall not apply to any producer who is an employee of an insurer or represents, by contractual agreement, only one insurer or a group of affiliated insurers under R.S. 22:691 et seq.

(4) Upon the written request of the owner of the policy or the first-named insured if there are multiple-named insureds, an insurer shall permit such owner or insured to select another appointed insurance producer due to the termination, death, or retirement of a producer of record or for any other reason deemed appropriate by such owner or insured. Any renewal commission owed to the former producer of record shall be paid to the new producer of record upon the next renewal of the policy.

(5) Nothing in this Subsection shall require an insurer to conduct business with a producer who is not appointed or otherwise not qualified by the insurer to conduct business with the insurer. However, if the producer is appointed or otherwise qualified by the insurer to conduct business with the insurer, the insurer shall recognize the producer as producer of record under the provisions of this Subsection and shall accord the producer all of the normal rights and privileges of a producer for the insurer.

(6) The commissioner of insurance may promulgate rules to enforce the provisions of this Subsection.

C. The provisions of this Section shall not apply to individually underwritten, guaranteed renewable limited benefit health insurance policies.

Producer Compensation

§1567. Producers' compensation in form of fees; commercial property and casualty insurance; criteria for policyholders

Notwithstanding any other provision of law to the contrary, an insurance producer may negotiate with both or either a property and casualty insurer or a commercial policyholder, including a governmental entity pursuant to R.S. 42:1123(37)(b), to compensate the insurance producer for the placement of commercial property and casualty insurance coverages by any combination of commissions, fees, or fees in lieu of commissions if the commercial insurance policyholder, including a governmental entity pursuant to R.S. 42:1123(37)(b), meets one of the following criteria:

(1) Has total annual property and casualty insurance premiums in excess of five hundred thousand dollars.

(2) Obtains insurance coverage with a per occurrence or per claim deductible or self-insured retention of fifty thousand dollars or more for workers' compensation, general liability, or automobile insurance coverages.

(3) Has a net worth in excess of twenty-five million dollars.

(4) Qualifies as a self-insurer with the state of Louisiana.

(5) Is a governmental entity that had a contract prior to August 9, 2010, with an insurance producer on a stipulated fee basis for the placement of commercial property and casualty insurance coverages.

§1568. Producer compensation for sales of health and welfare plans

A. A health insurance issuer shall establish one or more schedules of commission for the sale of each health insurance product by an insurance producer. Such schedules of commission shall be uniformly applied to all producers within the same schedule and shall be payable to all insurance producers licensed and appointed to sell the health insurance products of the issuer. The provisions of this Subsection shall not apply to any employee welfare benefit plan exclusively regulated by the United States Department of Labor pursuant to Section 514 of the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1144, or Section 4 of the same act, 29 U.S.C. 1003.

B. In addition to a commission for a health insurance product, a health insurance producer may negotiate a charge, fee, or any other form of compensation directly with the plan sponsor or employer group.

C. Each health insurance contract entered into prior to June 14, 2013, shall comply with the provisions of this Section at the annual anniversary or renewal date following June 14, 2013. This Section shall apply to political subdivisions as defined by R.S. 42:1102, except for any political subdivision that had a contract on June 14, 2013, with an insurance producer or health insurance plan on a net of commission or stipulated fee basis for the placement of group health insurance coverage.

Agency Fees

§22:855. Quoted premium shall include all charges; dollar amount required

A. The premium quoted by the insurer shall be a specific dollar amount which shall be inclusive of all fees, charges, premiums, or other consideration charged for the insurance or for the procurement thereof, except that:

(1) In any subsequent modification of the policy, the insurer may require that evidence of insurability be furnished at the insured's expense;

(2) The premium and premium tax on a surplus lines policy shall be separately stated on the declaration page.

B.(1) No insurer or its officer, employee, agent, broker, solicitor, or other representative shall charge or receive any fee, compensation, or consideration for insurance which is not included in the premium quoted to the insured and the premium specified in the policy delivered to the insured, except for the premium tax on a surplus lines policy which shall be separately stated, and except for reimbursement for expenses due the agent, and except for an agency fee, if any, as authorized hereunder.

(2)(a) The agent may receive reimbursement from the insured for expenses incurred by the agent directly related to the insurance coverage for the insured. In addition, the agent may charge a reasonable agency fee related to the services provided by the agent. Any reimbursement or agency fee shall be itemized separately on an invoice statement. A single invoice may be used to make known all charges. Each such charge must be prominently disclosed and itemized separately on the invoice.

(b) The reimbursement for expense and agency fees shall not be considered premium for any purpose, nor shall they be subject to premium taxes or surplus lines premium taxes. Agency fees for criminal bail bond or homeowners or personal automobile insurance that are standard risks insurable at standard rates shall not exceed twenty-five dollars.

(c) The commissioner of insurance may promulgate rules to enforce the provisions of this Section.

C. Each policy delivered to the insured shall have the full and accurate dollar amount of the premium disclosed on the policy, which shall be inclusive of all fees, charges, premiums, or other consideration charged for the insurance or for the procurement thereof, except that, in any subsequent modification of the policy, the insurer may require that evidence of insurability be furnished at the insured's expense, and except that the premium tax on a surplus lines policy shall be separately stated, and except for reimbursement of expenses and agency fees as authorized in Paragraph (B)(2).

D.(1) Any person who aids, assists in, or procures the preparation of any invoice, insurance policy or part thereof, or any other document used in the charging of any fee, compensation, or other consideration, except as provided in Subsections B and C of this Section, which is not included in the premium quoted by the insurer and in the premium disclosed on the policy shall be liable to the insured.

(2) In this Subsection, a person who procures the preparation of any document specified in Paragraph (1) includes a person who knowingly permits the preparation of such a document to be done or participated in by a subordinate or employee, whether or not that person directly ordered or caused the subordinate or employee to prepare the document. It shall not include a person furnishing typing, reproducing, or providing other clerical or mechanical assistance with respect to a document.

E.(1) Upon making a written finding that an amount in excess of the quoted premium has been received, the commissioner shall issue a written order to the person who received the excess amount to refund it to the person who paid it. Such amount shall be paid within thirty days after the date of the commissioner's order in the matter.

(2) Upon such determination, the person ordered to pay the refund may appeal to the Nineteenth Judicial District Court after paying to the commissioner a sum equal to one-half of the assessed refund. The commissioner shall keep any such sum paid in escrow and shall return it promptly to the payor if he prevails in the court proceeding. Thirty days after the commissioner's written findings or thirty days after final denial of the appeal, any order of the commissioner made pursuant to this Section shall be enforceable as a judgment under the Code of Civil Procedure.

F. Each violation of Subsection B or C of this Section shall be theft and a violation of R.S. 14:67.

G. The commissioner may assess one or more of the following penalties against any person who violates the provisions of this Section:

(1) A fine in an amount not greater than five thousand dollars,

(2) A suspension of an insurer's certificate of authority or an agent's, broker's, or solicitor's license, or

(3) A revocation of an insurer's certificate of authority or an agent's, broker's, or solicitor's license.

H. The provisions of this Section shall apply to all policies except life, accident, health, and reinsurance policies.

Agent Exclusive Use of Expirations

§23. Exclusive use of expirations

A.(1) Except as otherwise provided herein, for purposes of soliciting, selling, or negotiating the renewal or sale of insurance coverage, insurance products, or insurance services, an insurance producer shall have the exclusive use of expirations, records, or other written or electronic information directly related to an insurance application submitted by or an insurance policy written through an insurance producer. No insurance company, managing general agent, surplus lines insurance broker, wholesale broker, third party administrator, or residual markets including but not limited to the Louisiana Automobile Insurance Plan, the Louisiana Joint Reinsurance Plan, or the Louisiana Insurance Underwriting Plan, shall use such expirations, records, or other written or electronic information to solicit, sell, or negotiate the renewal or sale of insurance coverage, insurance products, or insurance services to the insured, either directly or by providing such information to others without the express written consent of the insurance producer.

(2) Such expirations, records, or other written or electronic information may be used to review an application, issue a policy, or for any other purpose necessary for placing such business through the insurance producer. Such expirations, records, or other written or electronic information may also be used for any other purpose which does not involve the soliciting, selling, or negotiating the renewal or sale of insurance coverage, insurance products, or insurance services.

B. This Section shall not apply:

(1) When the insured requests, individually or through another producer, that the insurance company renew the policy or write other insurance business.

(2) When the insurance producer has, by contract, agreed to act exclusively for one company or group of affiliated insurance companies, in which case the rights of the producer shall be determined by the terms of the producer's contract with that company or affiliated group.

(3) When the producer is in default for nonpayment of premiums or other monies due and owing for which the agent is in default under the producer's contract or other agreement with the insurer, unless there is a legitimate dispute as to monies owed.

(4) When the agency contract is terminated and the insurance company is required by law to continue coverage for the insured; however, in that event, the insurance company shall continue to pay the producer commissions on such policies that the company is required to renew during the thirty-six month period following the effective date of the termination or three years, whichever is sooner. The commission shall be at the insurer's prevailing commission rates in effect on the date of renewal for that class or

line of business in effect on the date of renewal for producers whose contracts are not terminated.

(5) To policies providing group coverage and health insurance.

C. The producer and insurer may in a written agreement, separate from the agency contract, mutually agree to terms different than the provisions set forth in this Section. The terms of any such agreement shall be negotiated in good faith between the parties.

D.(1) The commissioner of insurance may adopt rules, in accordance with the Administrative Procedure Act, to enforce the provisions of this Section and any violation of this Section or the rules adopted thereunder shall be subject to regulation by the commissioner of insurance under R.S. 22:18.

(2) In addition, the producer shall have a right to a claim for lost commissions. Such claim shall be resolved in accordance with the dispute resolution terms in the applicable contract or agreement. In the absence of any dispute resolution term, the parties shall attempt to resolve their dispute through mediation. If the claim is not resolved through mediation, the claim may be resolved through binding arbitration if the parties agree. In the absence of an agreement to resolve the claim through binding arbitration, the producer may maintain a civil action in a court of competent jurisdiction for lost commissions.

(3)(a) All life insurance, disability income, long-term care, and annuity files, whether paper or electronic, submitted to an insurance company, are owned by the insurance company. The producer who sold the policy has the right to retain a copy of the file submitted to the issuing company. The producer has the right to retain a copy of the file after terminating his affiliation with the issuing company, unless the producer and the issuing company agree in writing that the producer shall not have such a right. Should the issuing company wish to make copies of the information retained by the producer, such copies shall be made at the issuing company's expense.

(b) This Paragraph shall not apply to any policy issued under the home service marketing distribution system referenced in R.S. 22:1962(C).

(c) As used in this Paragraph, files include all records, written or electronic, that were gathered and maintained by the producer.

(d) Notwithstanding any other provision of this Paragraph to the contrary, information a producer may retain shall not include real-time data and updates maintained on the insurance company computer system or any data protected by the Gramm-Leach-Bliley Act, 15 U.S.C. 6801-15 U.S.C. 6809, or the security laws.

(4) Except as provided in this Section, nothing in this Section shall be interpreted as impairing any rights in law or contract currently enjoyed by any party.

Agent E&O Statute of Limitations

§5606. Actions for professional insurance agent liability

A. No action for damages against any insurance agent, broker, solicitor, or other similar licensee under this state, whether based upon tort, or breach of contract, or otherwise, arising out of an engagement to provide insurance services shall be brought unless filed in a court of competent jurisdiction and proper venue within one year from the date of the alleged act, omission, or neglect, or within one year from the date that the alleged act, omission, or neglect is discovered or should have been discovered. However, even as to actions filed within one year from the date of such discovery, in all events such actions shall be filed at the latest within three years from the date of the alleged act, omission, or neglect.

B. The provisions of this Section shall apply to all persons whether or not infirm or under disability of any kind and including minors and interdicts.

C. The peremptive period provided in Subsection A of this Section shall not apply in cases of fraud, as defined in Civil Code Article 1953.

D. The one-year and three-year periods of limitation provided in Subsection A of this Section are peremptive periods within the meaning of Civil Code Article 3458 and, in accordance with Civil Code Article 3461, may not be renounced, interrupted, or suspended.

Approval of Policy Forms

§861. Approval of forms

A.(1) No basic insurance policy form, other than fidelity or surety bond forms, or application form where written application is required and is to be attached to the policy, or be a part of the contract or printed life, annuity, or health and accident rider or endorsement form shall be issued, delivered, or used unless it has been filed with and approved by the commissioner of insurance.

(2) For purposes of this Section, a basic insurance policy form shall include a certificate of coverage, any other evidence of coverage, or a subscriber agreement.

(3) This Section shall not apply to policies, riders, or endorsements designed to delineate the coverage 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 such policy, and which is used at the request of the individual policyholder, contract holder, or certificate holder.

(4) Any insurer may insert in its policies any provisions or conditions required by its plan of insurance or method of operation which are not prohibited by the provisions of this Code.

B. Every such filing shall be made not less than forty-five days in advance of any such issuance, delivery, or use. At the expiration of forty-five days, the form so filed shall be deemed approved unless prior thereto it has been affirmatively approved or disapproved by order of the commissioner of insurance. The commissioner of insurance may extend by not more than an additional fifteen 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 forty-five-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 commissioner of insurance may withdraw any such approval at any time for cause. Approval of any such form by the commissioner of insurance shall constitute a waiver of any unexpired portion of such initial fifteen-day waiting period.

C. The commissioner of insurance's order disapproving any such form or withdrawing a previous approval shall state the grounds therefor.

D. No such form shall knowingly be so issued or delivered as to which the commissioner of insurance's approval does not then exist.

E. The commissioner of insurance, 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 opinion 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.

F. Insurers negotiating with and insuring special commercial entities shall be exempt from the form filing and approval requirements of this Section. The commissioner shall adopt rules and regulations necessary for the implementation of this Subsection including a provision defining special commercial entities which qualify for exemption. The definition of exempt commercial policyholder shall be reviewed periodically by the commissioner. This Subsection shall apply only to commercial property and casualty insurance. The regulations required by this Subsection shall be issued by the commissioner.

LDI Regulation 72

Commercial Lines Insurance Policy Form Deregulation

§9001. Authority

A. This regulation is adopted pursuant to R.S. 22:620F.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:620.F.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:500 (March 2000).

§9003. Purpose

A. The purpose of this regulation is to allow for more flexibility in the placement of insurance with large commercial risks within the parameters of the admitted market by establishing an exemption from the form filing, review and approval requirements of the Louisiana Insurance Code, and to adopt the initial definition of an "exempt commercial policyholder". The exemption implemented under this regulation is experimental. It is predicated upon the continued existence of an open and competitive market and the good faith of insurers in carrying out the fiduciary obligations owed to their insureds.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:620.F.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:500 (March 2000).

§9005. Scope and Applicability

A. This regulation applies to all authorized insurers engaged in the business of writing commercial risk property and casualty insurance in this state.

B. This regulation governs the circumstances under which an insurer may issue an insurance

policy to a policyholder without first filing the forms with and obtaining approval of the Commissioner of Insurance.

C. The exemption granted by this regulation is limited in scope to certain commercial risk insurance issued to special commercial entities as provided for in Sections 9011 and 9013 of this regulation, respectively.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3., R.S. 22:620.F.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:500 (March 2000).

§9007. Severability

A. If any section or provision of this regulation is held invalid, such invalidity shall not affect other sections or provisions which can be given effect without the invalid section or provision, and for this purpose the sections and provisions of this regulation are severable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:620.F.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:500 (March 2000).

§9009. Definitions

A. For the purposes of this regulation the following terms shall have the meaning ascribed herein, unless the context clearly indicates otherwise.

Affiliated Group-two or more persons who are owned or controlled directly or indirectly though one or more intermediaries by, or are under common control with, the person specified (i.e., the named insured) and includes a subsidiary.

Authorized Insurer-shall have the meaning found in R.S..22:5(13).

COI-the Commissioner of Insurance for the State of Louisiana.

Commercial Risk-any kind of risk that is not a personal risk.

Competitive Market-a market in which a reasonable degree of competition exists or which has not been found to be in violation of R.S. 22:1211 et seq. In determining whether a reasonable degree of competition exists within a line of insurance, the COI shall consider the following factors:

a. the number of insurers available to write the 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' cost to revenue over a reasonable period of time.

Insurer-shall have the meaning found in R.S. 22:5(2).

LDOI-the Louisiana Department of Insurance.

LIRC-the Louisiana Insurance Rating Commission.

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

Personal Risk-homeowners, tenants, private passenger nonfleet automobile, mobile home and other property and casualty insurance for personal, family or household needs.

State-the state of Louisiana.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:620.F.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:500 (March 2000).

§9011. Types of Coverage Exempt from Filing and Approval

A. All kinds of commercial property and casualty insurance, including but not limited to Commercial Property, Boiler and Machinery, Commercial Auto, General Liability, Directors and Officers, Business Owners and Inland Marine insurance, written on commercial risks are exempt from the filing and approval provisions of R.S. 22:620 if the policy is issued to an exempt commercial policyholder as defined in §9013 of this regulation, except for the following kinds:

1. worker's compensation and employer's liability insurance;

2. professional liability insurance.

B. The exemption provided for in this Section only applies to policy forms. Rate and rule filings must be made with the LIRC as required by law.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, R.S. 22:620.F and R.S. 22:1403.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:501 (March 2000).

§9013. Special Commercial Entities

A. *Special Commercial Entity*-a person who meets the criteria for an *exempt commercial policyholder*.

B. An *Exempt Commercial Policyholder*-any person who applies for or procures commercial risk insurance, of the kinds provided for in Section 9011, and meets the following criteria:

1. has and maintains aggregate annual commercial insurance premiums, excluding worker's compensation and employer's liability, and professional liability insurance premiums, of more than two hundred thousand ($200,000) dollars in the preceding fiscal year. In determining whether this threshold has been met, premiums paid to one or more insurers are to be added together to reach the total aggregate;

2. at the time the policy is issued the policyholder must have:

a. if a single company not less than 50 employees;

b. if a member of an affiliated group not less than 100 employees collectively;

c. if a municipality a population of not less than 50,000; and

d. if a public entity an operating budget of not less than $20,000,000 for the most recently completed calendar or fiscal year whichever applies;

3. has signed the certification form as provided for in §9015.B of this regulation.

C. Beginning January 1, 2001, the criteria in Subsection B of this Section must be reviewed on an annual basis by the COI for the purposes of determining whether the criteria should be modified. The review must be completed on or before the 31st day of March.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, R.S. 22:3, R.S. 22:620.F.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:501 (March 2000).

§9015. Disclosure Requirements and Certification Form

A. When soliciting, negotiating or procuring a policy of insurance with an exempt commercial policyholder the agent or broker, or the insurer in cases of direct placement, shall disclose to the policyholder and the policyholder's risk manager, if any, on a form created by the insurer, that a policy form may be used which is exempt from the form filing requirements of the Louisiana Insurance Code.

B. When a policy of insurance is issued or delivered to an exempt commercial policyholder, the insurance agent or broker, or the insurer in cases of direct placement, shall obtain from the policyholder a written certification on the form prescribed below. The certification form must be in not less than 10-point type, and it must be dated and signed by a senior officer or manager of the policyholder and the

policyholder's risk manager, if any.

Louisiana Certification of Exempt Commercial Policyholder Status Pursuant to Louisiana Regulation 72
The undersigned _____, (the Insured) certifies to _____ (the Insurer) that the Insured meets the criteria below and is an Exempt Commercial Policyholder under Louisiana law. The Insurer may issue a commercial risk insurance policy to an Exempt Commercial Policyholder without filing the policy form with the Louisiana Department of Insurance and the Insurer by signing below certifies that it has the necessary expertise to negotiate its own policy language. The policy must still comply with Louisiana law, and complaints or questions about compliance may be directed to the Louisiana Department of Insurance (1-800-259-5300).
In order to be an Exempt Commercial Policyholder, the Insured must:

1. Execute this Certification Form and return it to the Insurer.

2. Acquire the insurance policy through an insurance agent licensed in Louisiana.

3. Meet the following requirements:

· Have and maintain aggregate annual commercial risk insurance premiums, excluding workers compensation and employer's liability and professional liability insurance premiums of more than two hundred thousand ($200,000) dollars in the preceding fiscal year. In determining whether this threshold has been met, premiums paid to one or more insurers are to be added together to reach the total aggregate.

· At the time the policy is issued the policyholder must have (a) if a single company not less than fifty (50) employees; (b) if a member of an affiliated group not less than one hundred (100) employees collectively; (c) if a municipality a population of not less than fifty thousand (50,000); and, (d) if a public entity an operating budget of not less than twenty ($20,000,000) million dollars for the most recently completed calendar or fiscal year whichever applies.
Signed:_____
Date:_____
Printed:_____
Title:_____
Risk Manager:_____

C. The disclosure notice and certification form required by this section shall be effective for the life of the policy or policies, including renewals, unless the deductible, or policy limits or coverage is significantly modified, in which case a new certification form must be executed.

D. A copy of the certification form shall be maintained by the insurer and by the producing agent or broker in the policyholder's record for a period of five years from the date of issuance of the insurance policy or renewal policy if at renewal a new certification form is executed. The insurer or producing agent or broker shall make such certification forms available for examination by the COI or any person acting on behalf of the COI.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, R.S. 22:3; R.S. 22:620.F; R.S. 22:1211 et seq. and R.S. 22:1301.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:501 (March 2000).

§9017. Requirements for Maintaining Records

A. Any insurer who places insurance with an exempt commercial policyholder, pursuant to this regulation, shall maintain a record on the exempt commercial policyholder. The record shall contain, in addition to the certification form, the following information:

1. any data, statistics, rates, rating plans, rating systems and underwriting rules used in underwriting and issuing such policies;

2. a copy of the policy with date of issuance clearly marked;

3. annual experience data on each risk insured, including but not limited to:

a. written premiums;

b. written premiums at a manual rate;

c. paid losses;

d. outstanding losses;

e. loss adjustment expenses;

f. underwriting expenses;

g. underwriting profits; and

h. profits from contingencies; and

4. a record of all complaints including the date the complaint was made, the name of the complainant, the nature of the complaint and the final resolution.

B. The record required by this section may be kept in electronic or written form and shall be maintained by the insurer for a period of five years from the date of issuance of the insurance policy or renewal policy if a new certification form is required pursuant to §9015.C. Upon request, the insurer shall produce such record for examination by the COI or any person acting on behalf of the COI.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, R.S. 22:3, R.S. 22:1211 et seq. and R.S. 22:1301.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:502 (March 2000).

§9019. Exempt Policy Forms

A. Commercial risk property and casualty policy forms which would otherwise have to be filed with and approved by the COI are exempt from this requirement if issued to an exempt commercial policyholder. The exemption of the policy form from the requirement that it be filed with and approved by the COI is not to be taken by an insurer to mean that an insurance contract confected by the use of such a policy form, or policy forms, may in any manner be inconsistent with the statutory law of this state or public policy as expressed by the courts of this state.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, R.S. 22:3. and R.S. 22:620, and 22:1211 et seq.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:502 (March 2000).

§9021. Penalties for Failure to Comply

A. The exemption created by this regulation is a limited one and insurers must strictly comply with the conditions creating the exemption. Failure to comply with the regulation by any person subject to its provisions, after proper notice and a hearing held by the COI, may result in the imposition of such penalties as are authorized by law.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2, R.S. 22:3, R.S. 22:620; R.S. 22:1211 et seq., R.S. 22:1115 and R.S. 22:1457.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:502 (March 2000).

Approval of Rates

SUBPART O. RATE MAKING PROCEDURES AND ORGANIZATIONS

§1451. Systems for ratemaking

A. As used in this Subpart, the term "commissioner" shall mean the commissioner of insurance.

B. The commissioner shall have the exclusive authority to accept, review, and approve any application for insurance rates or rate changes for all lines of property and casualty insurance. The commissioner shall exercise his authority in accordance with the provisions of this Section.

C.(1) Subject to the exception specified in Subsection D of this Section, each filing submitted to the commissioner shall be on file for a waiting period of forty-five days before it becomes effective. Upon written application by such insurer or rating organization, the commissioner may authorize a filing which he has reviewed to become effective before the expiration of the waiting period. A filing shall be deemed to meet the requirements of this Subpart unless disapproved in writing by the commissioner within the forty-five-day waiting period. The commissioner may by rule, regulation, or order reduce or eliminate the waiting period specified in this Subsection. For any filing that is disapproved, the insurer may appeal such disapproval to the Nineteenth Judicial District Court within fifteen days from the receipt of written notice of disapproval.

(2) Unless notified by the commissioner that a filing is incomplete, or that the filing is disapproved pursuant to this Subpart, the insurer or rating organization may commence use of the filed rates upon expiration of forty-five days from the date of receipt by the commissioner.

D. Insurers negotiating with and insuring commercial entities, except with regard to workers' compensation and medical malpractice insurance, with at least ten thousand dollars in annual insurance premiums, shall be required to file insurance rates or rate changes for such entities with the commissioner for informational purposes only. The commissioner may by rule, regulation, or order reduce or eliminate the annual premium threshold for those entities that enables rate filings to be made under this Subsection.

E. All provisions of this Section shall be applicable when a competitive market in property and casualty lines insurance exists. The commissioner may determine if there exists a competitive or noncompetitive market pursuant to the provisions of R.S. 22:1453, including requiring reasonable notice and a public hearing prior to determining a market to be noncompetitive. If, after a public hearing, the commissioner determines the market to be noncompetitive, all rate filings shall follow the provisions of Subsection C of this Section without regard to the exception specified in Subsection D of this Section. An aggrieved party affected by the commissioner's decision, act, or order may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

F. No provision of this Section shall prohibit the commissioner from conducting market conduct exams to ensure the rates being charged by insurers are not inadequate, excessive, or unfairly discriminatory.

§1453. Competitive market

A.(1) A competitive market for a line of insurance is presumed to exist unless the commissioner, after giving reasonable notice and after conducting a public hearing, determines that a reasonable degree of competition does not exist within a market and issues a ruling that a reasonable degree of competition in the market for a particular line of insurance does not exist. In any public hearing to determine whether a competitive market exists for a line of insurance, the party alleging that competition does not exist shall have the burden of proving that market competition does not exist.

(2) If the commissioner issues a ruling pursuant to this Section that a competitive market does not exist for a line of insurance, the ruling shall identify those factors listed in Subsection B of this Section that have caused the market to be noncompetitive and shall describe the action or actions to be undertaken by the commissioner and the state to return competition to the market.

(3) Each ruling that a market is not competitive shall expire one year from the date of issuance unless rescinded by the commissioner prior to such date or renewed by the commissioner pursuant to this Subsection.

(4) The commissioner may renew a ruling that a market is not competitive if, after conducting a public hearing on such renewal, the commissioner determines that a continued lack of reasonable competition exists in the market for a line of insurance. The action to renew a finding of no competition under this Subsection shall state the actions undertaken by the commissioner and the state to restore competition and the reasons such actions failed to return competition to the market.

B. The following factors shall be considered by the commissioner in determining if a reasonable degree of competition exists in a particular line of insurance:

(1) The number of insurers or groups of affiliated insurers providing coverage in the market.

(2) Measures of market concentration and changes of market concentration over time.

(3) Ease of entry into the market and the existence of financial or economic barriers preventing new insurers from entering the market.

(4) The extent to which any insurer or group of affiliated insurers controls all or a portion of the market.

(5) Whether the total number of companies writing the line of insurance in this state is sufficient to provide multiple options.

(6) The availability of insurance coverage to consumers in the market.

(7) The opportunities available to consumers in the market to acquire pricing and other consumer information.

C. The commissioner shall regularly monitor the degree and existence of competition in the state. The commissioner may utilize existing relevant information, analytical systems, and other sources, or any combination of such items. These monitoring activities may be conducted within the Department of Insurance, in cooperation with other state insurance regulators, through outside contractors, or in any other appropriate manner.

D. An aggrieved party affected by the commissioner's decision, act, or order may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.

§1454. Rating standards and methods

A. Rates shall not be inadequate or unfairly discriminatory in a competitive market. Rates shall not be excessive, inadequate, or unfairly discriminatory in a noncompetitive market. Risks may be classified using any criteria except that no risk shall be classified on the basis of race, color, creed, or national origin.

B. In determining whether rates are excessive, inadequate, or unfairly discriminatory, consideration may be given to the following items:

(1) Basic rate factors. Due consideration shall be given to past and prospective loss and expense experience within and outside the state, catastrophe hazards and contingencies, events, or trends within and outside the state, dividends or savings to policyholders, members, or subscribers, and all other relevant factors and judgments. Fines and penalties against an insurer, whether levied by a court or regulatory body, shall not be used by the insurer or considered in any manner in the loss or expense experience for the purpose of setting rates or making rate filings.

(2) Classification. Risks may be grouped by classification for the establishment of rates and minimum premiums. Classification rates may be modified for individual risks in accordance with rating plans or schedules which establish standards for measuring probable variations in hazards or expenses, or both.

(3) Expenses. The expense provisions shall reflect the operating methods of the insurer, the past expense experience of the insurer, and anticipated future expenses.

(4) Contingencies and profits. The rates shall contain a provision for contingencies and a provision for a reasonable underwriting profit and shall reflect investment income directly attributable to unearned premium and loss reserves.

(5) Other relevant factors. Any other factors available at the time of the rate filing.

C. Except as provided by this Subpart, the commissioner shall not approve or otherwise regulate rates.

Acts 2007, No. 459, §1, eff. Jan. 1, 2008; Acts 2008, No. 402, §1, eff. June 21, 2008; Redesignated from R.S. 22:1402.2 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

NOTE: Former R.S. 22:1454 redesignated as R.S. 22:22 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

§1455. Rate regulation when market determined to be noncompetitive

A. If the commissioner determines that competition does not exist in a market and issues a noncompetitive ruling pursuant to R.S. 22:1453, the rates applicable to insurance sold in that market shall be regulated in accordance with the provisions of this Subpart applicable to noncompetitive markets.

B. Any rate filing in effect at the time the commissioner determines that competition does not exist shall be deemed to be in compliance with the laws of this state unless disapproved pursuant to the procedures and rating standards contained in this Subpart applicable to noncompetitive markets.

C. Any insurer having a rate filing in effect at the time the commissioner determines that competition does not exist may be required to furnish supporting information within thirty days of a written request by the commissioner.

Acts 2007, No. 459, §1, eff. Jan. 1, 2008; Redesignated from R.S. 22:1402.3 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

NOTE: Former R.S. 22:1455 redesignated as R.S. 22:41 by Acts 2008, No. 415, §1, eff. Jan. 1, 2009.

§1456. Scope of rate regulation

A. This Subpart applies to fire, marine and transportation, title insurance, and casualty insurance risks or operations in this state.

B.(1) For the purpose of this Subpart, fire insurance includes insurance coverage as defined in R.S. 22:47(10), (11)(b), and (12), and such other coverages as are usually written by fire insurers other than motor vehicle insurance; marine and transportation

insurance includes personal floater insurance and the kinds of insurance defined in R.S. 22:47(13) and such other inland marine coverages as may be so established by interpretation, by ruling of the commissioner of insurance, or by general customs of the business; title insurance includes the kind of insurance coverage as defined in R.S. 22:47(9); and casualty insurance includes the kinds of casualty insurance defined in R.S. 22:47(3), (4), (5), and (6), except personal property floater, R.S. 22:47(7), (8), and (11)(a), and such other coverages as are usually written by casualty insurers.

(2) Notwithstanding any other law to the contrary, any authorized insurer or approved unauthorized insurer providing liability coverage for public carrier vehicles, as defined by R.S. 45:200.2(2), shall be subject to the provisions of this Subpart.

C. This Subpart shall not apply:

(1) To reinsurance, other than joint reinsurance to the extent stated in R.S. 22:1472.

(2) To insurance of vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity; or other risks commonly insured under marine, as distinguished from inland marine, insurance policies.

(3) To insurance against loss or damage to aircraft or against liability, other than worker's compensation and employers' liability arising out of the ownership, maintenance or use of aircraft, nor to insurance of hulls of aircraft, including their accessories and equipment.

(4) To health and accident insurance.

D. If any kind of insurance, subdivision or combination thereof or type of coverage is subject to regulation under Sections of this Subpart, the provisions of which conflict, an insurer to which such conflicting provisions are otherwise applicable shall file with the commissioner of insurance a designation as to which of said sections shall be applicable to it with respect to such kind of insurance, subdivision or combination thereof or type of coverage.

§1465. Disapproval of filings; rates; procedures

A.(1) The commissioner shall disapprove a rate in a competitive market only if he determines that the rate is inadequate or unfairly discriminatory. The commissioner shall disapprove a rate for use in a noncompetitive market only if he determines that the rate is excessive, inadequate, or unfairly discriminatory.

(2) If within the forty-five-day waiting period or any extension of this period as provided in R.S. 22:1451, the commissioner finds that a filing does not meet the requirements of this Subpart, he shall send to the insurer or rating organization which made such filings

written notice of disapproval of such filing specifying wherein he finds such filing fails to meet the requirements of this Subpart and stating that such filing shall not become effective.

(3)(a) If at any time after a filing has become effective under R.S. 22:1451, the commissioner finds that a filing does not meet the requirements of this Subpart, he shall request a public hearing to be held upon not less than ten days' written notice, specifying the matters to be considered at such hearing to every insurer and rating organization which made such filing, and the commissioner shall thereafter issue an order specifying in what respects, if any, the commissioner finds that such filing fails to meet the requirements of this Subpart, and stating when, within a reasonable period thereafter, such filing shall be deemed no longer effective.

(b) If an insurer appeals the disapproval of a rate filing pursuant to R.S. 22:1469, the insurer may continue to use the disapproved rate pending a final ruling on such appeal. All funds collected by the insurer subsequent to the commissioner's rate disapproval but pending the final disposition of the appeal which are in excess of the previously approved rate shall be segregated and maintained by the insurer in an escrow account which shall be pledged to the commissioner for the benefit of the insureds.

B.(1) Any insurer whose rate filing is returned as incomplete more than once or disapproved or not acted upon within forty-five days from the date of receipt by the commissioner under this Subsection shall be given a public hearing upon written request made within thirty days of the return of the rate filing, disapproval of the rate filing, or inaction of the commissioner.

(2) If the commissioner, after conducting a public hearing, disapproves a new rate or rate change, he shall issue his order within thirty days of such hearing and shall specify the reasons why the new rate or rate change does not comply with the requirements of this Subpart. The commissioner's order shall state a date, not later than thirty days after the date of the order, on which the new rate or rate change shall be discontinued. Copies of said order shall be sent to every such insurer and rating organization. Said order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in said order.

C. Any person or organization aggrieved with respect to any filing which is in effect may demand a hearing in accordance with Chapter 12 of this Title, R.S. 22:2191 et seq.; however, the insurer or rating organization that made the filing shall not be authorized to proceed under this Subsection.

§1484. Property, casualty, and liability insurance; premium increase by insurer without or with material change in circumstances of insured; notice of premium increase

A.(1) No insurer shall be entitled to an additional premium for a commercial property, casualty, or liability insurance policy which has been in effect for more than ninety days or for a noncommercial property, casualty, or liability insurance policy which has been in

effect for more than sixty days when there has been no material change in the circumstances of the insured from those stated by the insured in his application for the policy. For an insurance company to be entitled to any additional premium, the insured must receive a billing notice and either an explanation of any premium increase or a statement that asks the insured to contact either the insurance company or its producer if the insured has any questions about the billing notice or the premium increase, within the first sixty days of the effective date of the policy. If the company or agent fails to bill the insured within the first sixty days of the effective date of the policy, the insured shall not be responsible for payment of such additional premium, shall not be penalized for nonpayment of that additional premium, and his policy shall not be cancelled for failure to pay such additional premium.

(2) A notice of an additional premium for a commercial property, casualty, or liability insurance policy which has been in effect for less than ninety days or for a noncommercial property, casualty, or liability insurance policy which has been in effect for less than sixty days when there has been a material change in the circumstances of the insured from those stated by the insured in his application for the policy shall be mailed or delivered to the insured at least thirty days prior to the date that the additional premium is due.

B. In this Section, "material change" shall mean any change in any matter which, if stated on the application, would have resulted in a different initial premium for the policy.

C. Nothing in this Section shall be construed to prevent an insurer from making rate changes at subsequent renewal dates of the policy.

D. This Section does not apply to audit type policies where the actual premium is to be determined at a later date.

E. This Section does not apply to property subject to ratings by the Property Insurance Association of Louisiana.

Regulation 80—Commercial Lines Insurance Rate Deregulation

§9301. Authority
A. This regulation is adopted pursuant to R.S. 22:3 and R.S. 22:1401.1(D).
AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:1401.1.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 30:2834 (December 2004).

§9303. Purpose
A. The purpose of this regulation is to implement the provision of Acts 2004, No. 878 of the Louisiana Legislature, Regular Session, which exempts commercial property and casualty insurers from the rate approval process unless the commissioner determines that the market for a line of insurance is noncompetitive. The regulation specifies the criteria the commissioner will use to determine if there exists a competitive or noncompetitive market.
AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:1401.1D.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 30:2834 (December 2004).

§9305. Scope and Applicability
A. This regulation applies to all authorized insurers engaged in the business of writing commercial property and casualty insurance in this state.
AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:1401.1D.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner LR 30:2834 (December 2004).
§9307. Severability
A. If any Section or provision of this regulation is held invalid, such invalidity shall not affect other sections of provisions which can be given effect without the invalid Section or provision, and for this purpose the Sections and provisions of this regulation are severable.
AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:1401.1D.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 30:2834 (December 2004).

§9309. Definitions
A. For the purposes of this regulation the following terms shall have the meaning ascribed herein unless the context clearly indicates otherwise.
Title 37, Part XIII
3 35 *Louisiana Administrative Code December 2009*
Affiliated Group—two or more persons who are owned or controlled directly or indirectly through one or more intermediaries by, or are under common control with, the

person specified (i.e., the named insured) and includes a subsidiary.
Anticompetitive Behavior—an insurer monopolizing or attempting to monopolize, or combine with or conspire with any person to monopolize, in any territory, the business of insurance of any kind, subdivision or class.
Authorized Insurer—shall have the meaning found in R.S. 22:5(3).
COI—the Commissioner of Insurance for the state of Louisiana.
Commercial Risk—any kind of risk that is not a personal risk.
Exempt Commercial Policyholder—a person who has and maintains an annual commercial insurance policy premium, excluding workers compensation and, if applicable, medical malpractice liability insurance premiums, of at least $10,000 in the preceding fiscal year.
Insurer—shall have the meaning found in R.S. 22:5(10).
LDOI—the Louisiana Department of Insurance.
Line of Insurance—the lines of business included on the Exhibit of Premiums and Losses (Statutory Page 14) of the Annual Statement Blank.
Noncompetitive Market—a market in which a reasonable degree of competition for a line of insurance does not exist as specified in §9315; or a market which has been found to exhibit anticompetitive behavior or otherwise be in violation of R.S. 22:1211 et seq.
Office of Property and Casualty—the office created by R.S. 36:688.
Person—an individual, a corporation, a partnership, an association, a trust, a joint stock company, an unincorporated organization, any similar entity, or any combination of the foregoing acting in concert.
Personal Risk—homeowners, tenants, private passenger nonfleet automobile, mobile home and other property and casualty insurance for personal, family or household needs.
State—the state of Louisiana.
AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:1401.1D.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 30:2834 (December 2004).

§9311. Types of Insurance Exempt from Rate Filing and Approval Process
A. All lines of commercial property and casualty

insurance, including but not limited to Commercial Property, Boiler and Machinery, Fire and Allied Lines, Commercial Auto, General Liability, Non-Medical Professional Liability, Business Owners and Inland Marine insurance, written on commercial risks are exempt from the filing and approval provisions of R.S. 22:1401 et seq., if the policy is issued to an exempt commercial policyholder as defined in §9309, except for the following kinds:
1. workers compensation; and
2. medical malpractice liability insurance.
AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:1401.1D.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 30:2835 (December 2004).

§9313. Exempt Rates
A. If, after holding a public hearing, the commissioner has declared the market for a line of insurance competitive, then the rates employed for that line are exempt from the filing and approval process. Any such public hearing shall comply with the open meetings law.
B. Exempt rates shall be used only when writing coverage on an exempt commercial policyholder. If exempt rates are used, an informational filing must be submitted to the Office of Property and Casualty.
AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:1401.1D.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 30:2835 (December 2004).

§9315. Noncompetitive Market; Public Notice and Hearing
A. If the commissioner has reason to believe that a noncompetitive market for a line of insurance exists he shall give public notice in the manner specified in R.S. 22:1354(C) and conduct a public hearing.
B.1 In determining whether a reasonable degree of competition does not exist within a line of insurance, the COI shall consider the following factors:
a. the number of insurers available to write the 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;
f. the relationship of insurers' cost to revenue over a reasonable period of time;
g. the availability of insurance coverage to consumers in the markets by specific geographical area, by line of insurance and by class of risk;

h. the extent to which any insurer or group of affiliated insurers controls all or a portion of the market; and
i. the opportunities available to consumers in the market to acquire pricing and other consumer information.
2. These factors must indicate that there is a competitive market in order for a determination to be made that the market is competitive for the line of business under review. If it is determined that a line of business is noncompetitive, the rates for that line of business shall be governed by the file and use provisions of R.S. 1401.1(B) until such time as a finding is made that the market is no longer noncompetitive.
C. The commissioner shall hold an investigatory hearing to determine if the market is noncompetitive if he receives a written request from an aggrieved policyholder or any other affected person or organization. The request must specify the grounds relied upon by the complainant.
AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:1401.1D.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 30:2835 (December 2004).

§9317. Disciplinary Hearings; Fines
A. If the commissioner has reason to believe that an insurer is engaging in anticompetitive behavior he may hold a hearing pursuant to an Order to Show Cause, ordering the insurer to appear and show cause why it should not be sanctioned. In making a determination as to whether an insurer is engaging in anticompetitive behavior, the commissioner may consider the factors listed in §9315.
B. The commissioner may hold a disciplinary hearing if he has reason to believe that an insurer is using exempt rates

with a policyholder who does not qualify as exempt commercial policyholders.

C. If the commissioner finds that an insurer has violated or otherwise failed to comply with the provisions of this regulation he may impose such fines as are authorized by law.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:1401.1D.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 30:2835 (December 2004.

§9319. Effective Date

A. This regulation shall take effect on January 1, 2005.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3 and R.S. 22:1401.1D.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 30:2836 (December 2004).

Use of Credit Information

§1504. Use of credit information

An insurer authorized to do business in Louisiana 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 nonrenew 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 an insured's renewal rates for personal insurance solely upon credit information, without consideration of any other applicable factor independent of credit information.

(4) Take an adverse action against a consumer solely because he does not have a credit card account or other credit history, 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 commissioner, if the insurer presents information that such an absence or inability relates to the risk by the insurer.

(b) Treats the consumer as if the applicant or insured had neutral credit information, as defined by the insurer.

(c) Excludes the use of credit information as a factor and uses only other underwriting criteria.

(6) Takes 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 one hundred and eighty days from the date the policy is first written or renewal is issued.

(7) Uses credit information unless not later than every thirty-six 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 Paragraph:

(a) At annual renewal, upon the request of a consumer or the consumer's agent, the insurer shall re-underwrite and re-rate 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 thirty-six months, if consistent with its underwriting guidelines.

(c) No insurer need obtain current credit information for an insured, notwithstanding the requirements of Subparagraph (a) of this Paragraph, if one of the following applies:

(i) The insurer is treating the consumer as otherwise approved by the commissioner.

(ii) The insured is in the most favorably priced tier of the insurer or group of affiliated insurers; however, the insurer shall have the discretion to order such report, if consistent with its underwriting guidelines.

(iii) Credit was not used for underwriting or rating such insured when the policy was initially written; however, the insurer shall have the discretion to use credit for underwriting or rating such insured upon renewal, if consistent with its underwriting guidelines.

(iv) The insurer reevaluates the insured beginning no later than thirty-six months after inception and thereafter based upon other underwriting or rating factors, excluding credit information.

(v) The insurer provides a documented offer to the insured on an annual basis of the insured's right to voluntarily request that their insurance credit score be rerun and reevaluated based on the current information available at the time of the insured's request.

(d) For personal policies in place prior to August 15, 2003, the insurer shall begin reevaluating renewal policies in compliance with this Section no later than thirty-six months from August 15, 2003, unless otherwise requested in accordance with Subparagraph (a) of this Paragraph or otherwise not required under Subparagraph (c) of this Paragraph.

(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 requested by the consumer for his own credit information, or inquiries not initiated by the consumer, including promotional inquiries, periodic inquiries by existing credit providers, and credit system administration inquiries.

(b) Inquiries relating to insurance coverage, if so identified on a consumer's credit report.

(c) Collection accounts with a medical industry code, if so identified on the consumer's credit report.

(d) Multiple lender inquiries, if coded by the consumer reporting agency on the consumer's credit report as being from the home mortgage industry and made within thirty days of one another, unless only one inquiry is considered.

(e) Multiple lender inquiries, if coded by the consumer reporting agency on the consumer's credit report as being from the automobile lending industry and made within thirty days of one another, unless only one inquiry is considered.

(f) The extension of available credit in excess of what the insurer deems reasonable, when the consumer has an otherwise acceptable credit history and does not present an increased underwriting or rating risk.

(9) Create unreasonable disparities between underwriting tier placement between different lines of personal insurance for the same applicant solely on the basis of credit information unless justified by actuarial or statistical data or sound underwriting criteria, without consideration of any other applicable underwriting factor independent of credit information and not expressly prohibited by Paragraph (1) of this Section.

(10) Use credit information which would increase the expiring premium, due to a change in credit information, for policies that renew between August 15, 2006, and December 31, 2006.

Certificates of Insurance

§890. Certificates of insurance

A. For the purposes of this Section:

(1) "Certificate" or "certificate of insurance" means any document, instrument, or record, including an electronic record, no matter how titled or described, which is prepared by an insurer or insurance producer and issued to a third person not a party to the subject insurance contract, as evidence of property and casualty insurance coverage. "Certificate" or "certificate of insurance" shall not mean an insurance binder.

(2) "Certificate holder" means any person, other than a policyholder, that is designated on a certificate of insurance as a "certificate holder" or any person, other than a policyholder, to whom a certificate of insurance has been issued by an insurer or insurance producer at the request of the policyholder.

(3) "Electronic record" shall have the meaning defined in R.S. 9:2602(7).

(4) "Insurance" shall have the meaning defined in R.S. 22:46(9).

(5) "Insurance producer" shall have the same definition as set forth in R.S. 22:1542.

(6) "Insurer" means an insurer as defined in R.S. 22:46(10) and any other person engaged in the business of making property and casualty insurance contracts, including but not limited to self-insurers, syndicates, risk purchasing groups, and similar risk transfer entities. "Insurer" shall not mean any person self-insured for purposes of workers' compensation, including any group self-insurance fund authorized pursuant to R.S. 23:1195 et seq., any interlocal risk management agency authorized pursuant to R.S. 33:1341 et seq., or any self-insured employer authorized pursuant to R.S. 23:1168 et seq.

(7) "Person" means any individual, company, insurer, organization, reciprocal or inter-insurance exchange, business, partnership, corporation, limited liability company, association, trust, or other legal entity, including any government or governmental subdivision or agency.

(8) "Policyholder" means a person who has contracted with a property or casualty insurer for insurance coverage.

(9) "Record" shall have the meaning defined in R.S. 9:2602(13).

(10) "Self-insurer" means any individual business or group of businesses which have created a risk purchasing group, risk retention plan, syndicate, or other form of self-

insurance covering property or casualty risk exposures. "Self-insurer" shall not mean any person self-insured for purposes of workers' compensation, including any group self-insurance fund authorized pursuant to R.S. 23:1195 et seq., any interlocal risk management agency authorized pursuant to R.S. 33:1341 et seq., or any self-insured employer authorized pursuant to R.S. 23:1168 et seq.

B. No property or casualty insurer or insurance producer may issue a certificate of insurance or any other type of document purporting to be a certificate of insurance that will affirmatively or negatively alter, amend, or extend the coverage provided by the referenced insurance policy. A certificate of insurance shall also not convey any contractual rights to the certificate holder.

C. No person, wherever located, may prepare, issue, or request the issuance of a certificate of insurance for risks located in this state unless the form has been filed with and approved by the commissioner of insurance. No person, wherever located, may alter or modify an approved certificate of insurance form unless the alteration or modification has been approved by the commissioner of insurance.

D. The commissioner of insurance shall disapprove a form filed under this Section or withdraw approval of a form if that form:

(1) Is unfair, misleading, or deceptive, or violates public policy.

(2) Violates any state statute or regulation validly promulgated by the commissioner of insurance.

(3) Requires certification of insurance coverages that are not available.

E. The commissioner may approve a certificate of insurance form that does not state that the form is provided for information only or similar language, provided that the form states that the certificate of insurance does not confer any rights or obligations other than those conveyed by the policy and that the terms of the policy control. Further, use of such a form shall not be, in and of itself, cause for disapproval by the commissioner under the provisions of Subsection D of this Section.

F.(1) The commissioner of insurance shall approve or disapprove certificate of insurance forms filed pursuant to this Section in writing within forty-five days of receipt of the form.

(2) Standard certificate of insurance forms promulgated by the Association for Cooperative Operations Research and Development (ACORD), the American Association of Insurance Services (AAIS), or the Insurance Services Office (ISO) shall be filed, but are deemed approved by the commissioner of insurance, provided these forms comply with the provisions of this Section.

G. No person shall demand or request the issuance of a certificate of insurance from an insurer, insurance producer, or policyholder that contains any false or misleading information concerning the policy of insurance to which the certificate makes reference.

H. No person may prepare, issue, or request, either in addition to or in lieu of a certificate of insurance, an opinion letter or other document or correspondence, instrument, or record, including an electronic record, that is inconsistent with this Section; however, an insurer or insurance producer may prepare or issue an addendum that clarifies, explains, summarizes, or provides a statement of the coverages provided by a policy of insurance and otherwise complies with the requirements of this Section.

I. The provisions of this Section shall apply to all certificate holders, policyholders, insurers, insurance producers, and certificate of insurance forms issued as a statement or evidence of insurance coverages on property, operations, or risks located in this state, regardless of where the certificate holder, policyholder, insurer, or insurance producer is located.

J. A certificate of insurance form which has been approved by the commissioner and properly executed and issued by a property and casualty insurer or an insurance producer, shall constitute a confirmation that the referenced insurance policy has been issued or that coverage has been bound notwithstanding the inclusion of "for information purposes only" or similar language on the face of the certificate. 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 or any validly executed endorsements of insurance provides.

K. No certificate of insurance shall contain references to legal or insurance requirements contained in any contracts other than the underlying contracts of insurance, including construction or service contracts.

L. A person shall have a legal right to notice of cancellation, nonrenewal, or any material change, or any similar notice concerning a policy of insurance only if the person is named within the policy or any endorsement and the policy or endorsement, law, or regulation of this state 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 in accordance with the laws and regulations of this state and cannot be altered by a certificate of insurance.

M. Any certificate of insurance and any attached addendum prepared, issued, or requested in violation of this Section shall be null and void and of no force and effect.

N. Any person who willfully violates this Section may be fined not more than one thousand dollars per violation.

O. The commissioner of insurance shall have the power to examine and investigate any complaint or allegation of specific violations by any person who has allegedly engaged in an act or practice prohibited by this Section and to enforce the provisions of this Section. Examinations or complaint investigations conducted by the commissioner under this Subsection shall be subject to the provisions of R.S. 22:1983(J).

P. Pursuant to the Administrative Procedure Act, the commissioner of insurance may adopt reasonable rules and regulations as are necessary or proper to carry out the purposes of this Section.

Calendar Year Storm Deductibles

§1337. Homeowners' insurance deductibles applied to named-storms, hurricanes, and wind and hail deductibles

A. For purposes of this Section, the following definitions shall apply:

(1) "Hurricane" means a storm system that has been declared a hurricane by the National Hurricane Center of the National Weather Service.

(2) "Named storm" means a storm system that has been declared a named storm by the National Hurricane Center of the National Weather Service.

(3) "Separate deductible" means a deductible that applies to damage incurred during a specified weather event and may be expressed as a percentage of the insured value of the property or as a specific dollar amount and includes hurricane, named-storm, and wind and hail deductibles.

B. For all homeowners' insurance policies or other policies insuring a one- or two-family owner occupied premises for fire and allied lines, issued or renewed by authorized insurers on or after January 1, 2010, any separate deductible that applies in place of any other deductible to loss or damage resulting from a named storm or hurricane shall be applied on an annual basis to all named-storm or hurricane losses that are subject to the separate deductible during the calendar year.

C. If an insured incurs named-storm or hurricane losses from more than one named storm or hurricane during a calendar year that are subject to the separate deductible referred to in Subsection B of this Section, the insurer may apply a deductible to the succeeding named storms or hurricanes that is equal to the remaining amount of the separate deductible, or the amount of the deductible that applies to all perils other than a named storm or hurricane, whichever is greater. Insurers may require policyholders to maintain receipts or other records of such losses in order to apply such losses to subsequent named-storm or hurricane claims.

Claims & Bad Faith Settlement

§1973. Good faith duty; claims settlement practices; cause of action; penalties

A. An insurer, including but not limited to a foreign line and surplus line insurer, owes to his insured a duty of good faith and fair dealing. The insurer has an affirmative duty to adjust claims fairly and promptly and to make a reasonable effort to settle claims with the insured or the claimant, or both. Any insurer who breaches these duties shall be liable for any damages sustained as a result of the breach.

B. Any one of the following acts, if knowingly committed or performed by an insurer, constitutes a breach of the insurer's duties imposed in Subsection A of this Section:

(1) Misrepresenting pertinent facts or insurance policy provisions relating to any coverages at issue.

(2) Failing to pay a settlement within thirty days after an agreement is reduced to writing.

(3) Denying coverage or attempting to settle a claim on the basis of an application which the insurer knows was altered without notice to, or knowledge or consent of, the insured.

(4) Misleading a claimant as to the applicable prescriptive period.

(5) Failing to pay the amount of any claim due any person insured by the contract within sixty days after receipt of satisfactory proof of loss from the claimant when such failure is arbitrary, capricious, or without probable cause.

(6) Failing to pay claims pursuant to R.S. 22:1893 when such failure is arbitrary, capricious, or without probable cause.

C. In addition to any general or special damages to which a claimant is entitled for breach of the imposed duty, the claimant may be awarded penalties assessed against the insurer in an amount not to exceed two times the damages sustained or five thousand dollars, whichever is greater. Such penalties, if awarded, shall not be used by the insurer in computing either past or prospective loss experience for the purpose of setting rates or making rate filings.

D. The provisions of this Section shall not be applicable to claims made under health and accident insurance policies.

E. Repealed by Acts 1997, No. 949, §2.

F. The Insurance Guaranty Association Fund, as provided in R.S. 22:2051 et seq., shall not be liable for any special damages awarded under the provisions of this Section.

§1892. Payment and adjustment of claims, policies other than life and health and accident; personal vehicle damage claims; extension of time to respond to claims during emergency or disaster; penalties; arson-related claims suspension

A.(1) All insurers issuing any type of contract, other than those specified in R.S. 22:1811, 1821, and Chapter 10 of Title 23 of the Louisiana Revised Statutes of 1950, shall pay the amount of any claim due any insured within thirty days after receipt of satisfactory proofs of loss from the insured or any party in interest. The insurer shall notify the insurance producer of record of all such payments for property damage claims made in accordance with this Paragraph.

(2) All insurers issuing any type of contract, other than those specified in R.S. 22:1811, R.S. 22:1821, and Chapter 10 of Title 23 of the Louisiana Revised Statutes of 1950, shall pay the amount of any third party property damage claim and of any reasonable medical expenses claim due any bona fide third party claimant within thirty days after written agreement of settlement of the claim from any third party claimant.

(3) Except in the case of catastrophic loss, the insurer shall initiate loss adjustment of a property damage claim and of a claim for reasonable medical expenses within fourteen days after notification of loss by the claimant. In the case of catastrophic loss, the insurer shall initiate loss adjustment of a property damage claim within thirty days after notification of loss by the claimant except that the commissioner may promulgate a rule for extending the time period for initiating a loss adjustment for damages arising from a presidentially declared emergency or disaster or a gubernatorially declared emergency or disaster up to an additional thirty days. Thereafter, only one additional extension of the period of time for initiating a loss adjustment may be allowed and must be approved by the Senate Committee on Insurance and the House Committee on Insurance, voting separately. Failure to comply with the provisions of this Paragraph shall subject the insurer to the penalties provided in R.S. 22:1973.

(4) All insurers shall make a written offer to settle any property damage claim, including a third-party claim, within thirty days after receipt of satisfactory proofs of loss of that claim.

B.(1) Failure to make such payment within thirty days after receipt of such satisfactory written proofs and demand therefor or failure to make a written offer to settle any property damage claim, including a third-party claim, within thirty days after receipt of satisfactory proofs of loss of that claim, as provided in Paragraphs (A)(1) and (4) of this Section, respectively, or failure to make such payment within thirty days after written agreement or settlement as provided in Paragraph (A)(2) of this Section when such failure is found to be arbitrary, capricious, or without probable cause, shall subject the insurer to a penalty, in addition to the amount of the loss, of fifty percent damages on the amount found to be due from the insurer to the insured, or one thousand dollars, whichever is greater, payable to the insured, or to any of said employees, or in the event a partial payment or tender has been made, fifty percent of the difference between the amount paid or tendered and the amount found to be due as well as

reasonable attorney fees and costs. Such penalties, if awarded, shall not be used by the insurer in computing either past or prospective loss experience for the purpose of setting rates or making rate filings.

(2) The period set herein for payment of losses resulting from fire and the penalty provisions for nonpayment within the period shall not apply where the loss from fire was arson related and the state fire marshal or other state or local investigative bodies have the loss under active arson investigation. The provisions relative to time of payment and penalties shall commence to run upon certification of the investigating authority that there is no evidence of arson or that there is insufficient evidence to warrant further proceedings.

(3) The provisions relative to suspension of payment due to arson shall not apply to a bona fide lender which holds a valid recorded mortgage on the property in question.

(4) Whenever a property damage claim is on a personal vehicle owned by the third party claimant and as a direct consequence of the inactions of the insurer and the third party claimant's loss the third party claimant is deprived of use of the personal vehicle for more than five working days, excluding Saturdays, Sundays, and holidays, the insurer responsible for payment of the claim shall pay, to the extent legally responsible, for reasonable expenses incurred by the third party claimant in obtaining alternative transportation for the entire period of time during which the third party claimant is without the use of his personal vehicle. Failure to make such payment within thirty days after receipt of adequate written proof and demand therefor, when such failure is found to be arbitrary, capricious, or without probable cause shall subject the insurer to, in addition to the amount of such reasonable expenses incurred, a reasonable penalty not to exceed ten percent of such reasonable expenses or one thousand dollars whichever is greater together with reasonable attorneys fees for the collection of such expenses.

(5) When an insurance policy 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, and the insurer elects a cash settlement based on the actual cost to purchase a comparable motor vehicle, such costs shall be derived by using one of the following:

(a) A fair market value survey conducted using qualified retail automobile dealers in the local market area as resources. If there are no dealers in the local market area, the nearest reasonable market can be used.

(b) The retail cost as determined from a generally recognized used motor vehicle industry source; such as, an electronic database, if the valuation documents generated by the database are provided to the first-party claimant, or a guidebook that is available to the general public. If the insured demonstrates, by presenting two independent appraisals, based on measurable and discernable factors, including the vehicle's preloss condition, that the vehicle would have a higher cash value in the local market

area than the value reflected in the source's database or the guidebook, the local market value shall be used in determining the actual cash value.

(c) A qualified expert appraiser selected and agreed upon by the insured and insurer. The appraiser shall produce a written nonbinding appraisal establishing the actual cash value of the vehicle's preloss condition.

(d) For the purposes of this Paragraph, local market area shall mean a reasonable distance surrounding the area where a motor vehicle is principally garaged, or the usual location of the vehicle covered by the policy.

C.(1) All claims brought by insureds, worker's compensation claimants, or third parties against an insurer shall be paid by check or draft of the insurer to the order of the claimant to whom payment of the claim is due pursuant to the policy provisions, or his attorney, or upon direction of such claimant to one specified; however, the check or draft shall be made jointly to the claimant and the employer when the employer has advanced the claims payment to the claimant. Such check or draft shall be paid jointly until the amount of the advanced claims payment has been recovered by the employer.

(2) No insurer shall intentionally or unreasonably delay, for more than three calendar days, exclusive of Saturdays, Sundays, and legal holidays, after presentation for collection, the processing of any properly executed and endorsed check or draft issued in settlement of an insurance claim.

(3) Any insurer violating this Subsection shall pay the insured or claimant a penalty of two hundred dollars or fifteen percent of the face amount of the check or draft, whichever is greater.

D.(1) When making a payment incident to a claim, no insurer shall require that as a condition to such payment, repairs be made to a motor vehicle, including window glass repairs or replacement, in a particular place or shop or by a particular entity. Any insurer violating the provisions of this Subsection shall be fined not more than five hundred dollars for each offense.

(2) A violation of this Subsection shall constitute an additional ground, under R.S. 22:1554, for the commissioner to refuse to issue a license or to suspend or revoke a license issued to any producer to sell insurance in this state.

Unfair Trade Practices

§22:1964. Methods, acts, and practices which are defined herein as unfair or deceptive

The following are declared to be unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(1) Misrepresentations and false advertising of insurance policies. Making, issuing, circulating, or causing to be made, issued, or circulated any estimate, illustration, circular or statement, sales presentation, omission, or comparison that does any of the following:

(a) Misrepresents the benefits, advantages, conditions, or terms of any policy issued or to be issued.

(b) Misrepresents the dividends or share of the surplus to be received on any policy.

(c) Makes a false or misleading statement as to the dividends or share of surplus previously paid on similar policies.

(d) Makes 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.

(e) Misrepresents to any policyholder insured by any insurer for the purpose of inducing or tending to induce such policyholder to lapse, forfeit, or surrender his insurance.

(f) Uses any name or title of any policy or class of policies misrepresenting the true nature thereof.

(g) Is a misrepresentation for the purpose of effecting a pledge or assignment or effecting a loan against any policy.

(h) Misrepresents any policy as being shares of stock.

(2) False information and advertising generally. Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading.

(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 or tending to result in unreasonable restraint of, or a monopoly in, the business of insurance.

(5) False financial statements and false entries.

(a) Knowingly filing with any supervisory or other public official, or knowingly making, publishing, disseminating, circulating, or delivering to any person, or placing before the public, or knowingly causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false material statement of fact as to the financial condition of any insurer.

(b) Knowingly making any false entry of a material fact in any book, report, or statement of any insurer or knowingly 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, or knowingly making any false material statement to any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to which such insurer is required by law to report, or which has authority by law to examine into its condition or into any of its affairs.

(6) Stock operations and advisory board contract. 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 corporation, or securities or any special advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insure.

(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, provided that, in determining the class, consideration may be given to the nature of the risk, plan of insurance, the actual or expected expense of conducting the business or any other relevant factor.

(b) Making or permitting any unfair discrimination between individuals of the same class involving essentially the same hazards in the amount of premium, policy fees, or rates charged for any policy or contract of health or accident insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever, provided that, in determining the class, consideration may be given to

the nature of the risk, plan of insurance, the actual or expected expense of conducting the business or any other relevant factor.

(c) Violating the provisions of R.S. 22:34.

(d) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazard by refusing to insure, refusing to renew, cancelling, or limiting the amount of insurance coverage on a property or casualty risk solely because of the geographic location of the risk, unless such action is a result of the application of sound underwriting and actuarial principles related to actual or reasonably anticipated loss experience.

(e) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to insure, refusing to renew, cancelling, or limiting the amount of insurance coverage on the residential property risk, or the personal property contained therein, solely because of the age of the residential property.

(f) Refusing to insure, refusing to continue to insure, or limiting the amount of coverage available to an individual solely because of the sex, marital status, race, religion, or national origin of the individual. However, nothing in this Subsection shall prohibit an insurer from taking marital status into account for the purpose of defining persons eligible for dependent benefits. Nothing in this Section shall prohibit or limit the operation of fraternal benefit societies.

(g) Terminating or modifying coverage, or refusing to issue or refusing to renew any property or casualty policy solely because the applicant or insured or employee of either is mentally or physically impaired, unless the applicant, insured, or employee is mentally and physically incapable of operating an automobile and does not possess a valid operator's license issued by the state. However, this Subsection shall not apply to accident health insurance sold by a casualty insurer and shall not be interpreted to modify any other provision of law relating to the termination, modification, issuance, or renewal of any insurance policy or contract.

(h) Refusing to insure solely because another insurer has refused to write a policy, or has cancelled or has refused to renew an existing policy in which that person was the named insured. Nothing herein contained shall prevent the termination of an excess insurance policy on account of the failure of the insured to maintain any required underlying insurance.

(i) With regard to automobile liability insurance, terminating or modifying coverage, or refusing to issue or refusing to renew any policy solely because the applicant or insured filed for bankruptcy. This Subparagraph shall not apply where the refusal to continue to insure is based upon nonpayment of premium.

(j) With regard to automobile liability insurance, refusing to issue insurance coverage or increasing insurance premiums solely based upon a lapse in insurance coverage where the insured is serving in the military and has been deployed and has performed military services out of state and where the individual has previously surrendered his automobile license number plate to the office of motor vehicles in compliance with R.S. 47:505(B). This Paragraph shall apply to all existing and new insurance policies as well as renewals of existing policies.

(8) Rebates. Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any contract of insurance including life insurance, life annuity or health and accident 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 such insurance, or annuity, 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; or giving, or selling, or purchasing or offering to give, sell, or purchase as inducement to such insurance or annuity or in connection therewith, any stock, bonds, or other securities of any insurer or other corporation, association, or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract.

Nothing in paragraph (7) or this paragraph (8) of this Sub-section shall be construed as including within the definition of discrimination or rebates any of the following practices:

(a) 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 insurer and its policyholders;

(b) In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have paid premiums in advance or continuously for a specified period made premium payment directly to an office of the insurer in an amount which fairly represents the saving in collection expense;

(c) Readjustment of the rate of premium for a group insurance policy based on the loss or expense experience thereunder, at the end of the first year or of any subsequent year of insurance thereunder, which may be made retroactive only for such policy year;

(d) Agents accepting on their own responsibility, notes for the first premiums.

(9) Requiring as a condition precedent to lending money upon the security of a mortgage on movable or immovable property that the borrower negotiate any policy of insurance covering such property through a particular insurance agent or agents, company or companies, type of company or types of companies, broker or brokers. Provided, however, that this provision shall not prevent the exercise by any mortgagee of his right to approve the insurer selected by the borrower on a reasonable

non-discriminatory basis related to the solvency of the company and its ability to service the policy. The mortgagee may require that the amount of insurance be at least in an amount to protect the amount of the loan on a type of policy furnishing reasonable protection to the mortgagee in a form selected by the borrower which may include additional coverages not inuring to the benefit of the mortgagee and reasonably associated or connected with the property which is the subject of the loan or mortgage. Notwithstanding the provisions of R.S. 22:1962, any lender either directly or indirectly requiring a borrower to furnish insurance upon such property shall be subject to the conditions and prohibitions of this paragraph.

(10) Tying, which shall mean the following:

(a) The requirement by a health and accident agent or group health and accident insurer, individual health and accident insurer, or health maintenance organization, as a condition to the offer or sale of a health benefit plan to a group or individual insured, that such insured purchase any other insurance policy.

(b) Tying of a purchase of a health and life insurance policy or policies to another insurance product. "Tying" is the requirement by any small employer health insurance carrier or individual health insurance carrier, as a condition to the offer or sale of a health benefit plan, health maintenance organization, or prepaid limited health care service plan to a small employer, as defined by this Code, or to an individual, that such employer or individual purchase any other insurance product.

(c) Tying does not include the joint sale of group life and group health coverages or the joint sale of group life and/or group health and any other employee benefit plan.

(11) No person, as defined in R.S. 22:46(6), shall directly or indirectly participate in any plan to offer or effect any kind or kinds of life or health insurance and annuities as an inducement to or in connection with the purchase by the public of any goods, securities, commodities, services or subscriptions to periodicals. This paragraph shall not apply to such insurance, written in connection with an indebtedness, one of the purposes of which is to pay the indebtedness in case of the death or disability of the debtor. Nor shall this paragraph apply to the sale by life insurance agents, or by life insurance companies of equity products, including equities, mutual funds, shares of investment companies, variable annuities, and including face amount certificates of regulated investment companies under offerings registered with the Federal Securities and Exchange Commission.

(12) Any violation of any prohibitory law of this state.

(13) Fraudulent insurance act. A fraudulent insurance act is one committed by a person who knowingly and with intent to defraud presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker, or any agent thereof, any written statement as part of, or in support of, or in opposition to an application for the issuance of, or the rating of an insurance policy

for commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which he knows to contain materially false information concerning any fact material thereto; or conceal for the purpose of misleading information concerning any fact material thereto.

(14) Unfair claims settlement practices. Committing or performing with such frequency as to indicate a general business practice any of the following:

(a) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue.

(b) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.

(c) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.

(d) Refusing to pay claims without conducting a reasonable investigation based upon all available information.

(e) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed.

(f) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.

(g) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds.

(h) Attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application.

(i) Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of, the insured.

(j) Making claims payments to insureds or beneficiaries not accompanied by statement setting forth the coverage under which the payments are being made.

(k) Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

(l) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring the

subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information.

(m) Failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

(n) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

(o) Failing to provide forms necessary to present claims within fifteen calendar days of a request with reasonable explanations regarding their use, if the insurer maintains the forms for that purpose.

(15)(a) The issuance, delivery, issuance for delivery, or renewal of, or execution of a contract for, a health benefits policy or plan which:

(i) Prohibits or limits a person who is an insured or other beneficiary of the policy or plan from selecting a pharmacy or pharmacist of the person's choice to be a provider under the policy or plan to furnish pharmaceutical services or pharmaceutical products offered or provided by that policy or plan or in any manner interferes with that person's selection of a pharmacy or pharmacist, provided that the chosen pharmacy or pharmacist agrees in writing to provide pharmaceutical services and pharmaceutical products that meet all the terms and requirements, including the same administrative, financial, and professional conditions and a minimum contract term of one year if requested, that apply to all other pharmacies or pharmacists who have been designated as providers under the policy or plan or as participating providers in a pharmacy network established by the policy or plan.

(ii) Denies a pharmacy or pharmacist the right to participate as a contract provider of pharmaceutical services or pharmaceutical products under the policy or plan, or under a pharmacy network established by the policy or plan, if the pharmacy or pharmacist agrees in writing to provide pharmaceutical services and pharmaceutical products that meet all the terms and requirements, including the same administrative, financial, and professional conditions and a minimum contract term of one year, if requested, which apply to pharmacies and pharmacists which have been designated as providers under the policy or plan or as participating providers in a pharmacy network established by the policy or plan.

(b) This Paragraph shall not, however, require a health benefits policy or plan to provide pharmaceutical services or pharmaceutical products.

(c) As used in this Paragraph, the following terms shall be given these meanings:

(i) "Drug" and "prescription" have the meanings assigned by R.S. 37:1171 and regulations of the Louisiana Board of Pharmacy.

(ii) "Health benefits policy or plan" means any and all health and accident insurance policies or contracts, including but not limited to individual, group, family, family group, blanket, and association health and accident insurance policies, as well as health maintenance organizations and preferred provider organizations, and any and all other third-party payment plans or contracts, and any and all other health care or health benefits plans, policies, contracts, or funds that either in whole or in part provide benefits for pharmaceutical services and pharmaceutical products that are necessary as a result of or to prevent an accident or sickness.

(iii) "Interferes" or "interferes with" means and includes but is not limited to the charging to or imposing on an insured or other beneficiary who does not utilize a specified or designated pharmacy or pharmacist, a copayment fee or other condition not equally charged to or imposed on all insureds or other beneficiaries in or under the same program or policy or plan. However, "interferes" or "interferes with" does not mean or include the advertisement, or periodic dissemination, to all insureds or other beneficiaries of current lists of all pharmacies or pharmacists who have agreed to participate as a contract provider pursuant to the requirements of R.S. 22:1964(15)(a)(ii).

(iv) "Pharmaceutical product" means a "drug" and "prescription", as defined in this Paragraph, and home intravenous therapies.

(v) "Pharmaceutical services" means services that are ordinarily and customarily rendered by a pharmacy or pharmacist, including the preparation and dispensing of pharmaceutical products.

(vi) "Pharmacist" means a person licensed to practice pharmacy under the Pharmacy Law and Board of Pharmacy regulations of the state of Louisiana.

(vii) "Pharmacy" has the meaning assigned by R.S. 37:1171 and regulations of the Louisiana Board of Pharmacy.

(d) This Paragraph shall be cited as the "Patient Pharmacy Preference Act".

(16) Failure to maintain marketing and performance records. Failure of an insurer to maintain its books, records, documents, and other business records in such an order that data regarding complaints, claims, rating, underwriting, and marketing are accessible and retrievable for examination by the insurance commissioner. Data for at least the current calendar year and the two preceding years shall be maintained.

(17) Failure to maintain adequate complaint handling procedures. Failure of any insurer to maintain a complete record of all the complaints that it received since the date of its last examination. 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 purposes of this Paragraph, "complaint" shall mean any written communication primarily expressing a grievance received by the insurer from the Department of Insurance.

(18) Misrepresentation in insurance application. Making false or fraudulent statements or representations on or relative to an application for a policy, for the purpose of obtaining a fee, commission, money, or other benefit from any provider or individual person.

(19) Unfair financial planning practices. An insurance producer:

(a) Holding himself out, directly or indirectly, to the public as a "financial planner", "investment adviser", "consultant", "financial counselor", or any other specialist engaged in the business of giving financial planning or advice relating to investments, insurance, real estate, tax matters, or trust and estate matters when such person is in fact engaged only in the sale of policies.

(b)(i) Engaging in the business of financial planning without disclosing to the client prior to the execution of the agreement provided for in Subparagraph (c) or solicitation of the sale of a product or service that:

(aa) He is also an insurance salesperson.

(bb) That a commission for the sale of an insurance product will be received in addition to a fee for financial planning, if such is the case.

(ii) The disclosure requirement under this Paragraph may be met by including it in any disclosure required by federal or state securities law.

(c)(i) Charging fees other than commissions for financial planning by insurance producer, unless such fees are based upon a written agreement, signed by the party to be charged in advance of the performance of the services under the agreement. A copy of the agreement shall be provided to the party to be charged at the time the agreement is signed by the party.

(aa) The services for which the fee is to be charged shall be specifically stated in the agreement.

(bb) The amount of the fee to be charged or how it will be determined or calculated shall be specifically stated in the agreement.

(cc) The agreement shall state that the client is under no obligation to purchase any insurance product through the insurance agent, broker, or consultant.

(ii) The insurance producer shall retain a copy of the agreement for not less than three years after completion of services, and a copy shall be available to the commissioner upon request.

(20) Failure to provide claims history.

(a) Loss information - property and casualty. Failure of a company issuing property and casualty insurance to provide the following loss information for the three previous policy years to the first named insured within thirty days of receipt of the first named insured's written request:

(i) On all claims, date, and description of occurrence, and total amount of payments.

(ii) For any occurrence not included in Item (i) of this Paragraph, the date and description of occurrence.

(b) Should the first named insured be requested by a prospective insurer to provide detailed loss information in addition to that required under Subparagraph (a), the first named insured may mail or deliver a written request to the insurer for the additional information. No prospective insurer shall request more detailed loss information than reasonably required to underwrite the same line or class of insurance. The insurer shall provide information under this Subparagraph to the first named insured as soon as possible, but in no event later than twenty days of receipt of the written request. Notwithstanding any other provision of this Section, no insurer shall be required to provide loss reserve information, and no prospective insurer may refuse to insure an applicant solely because the prospective insurer is unable to obtain loss reserve information.

(c) The commissioner may promulgate regulations to exclude the providing of the loss information as outlined in Subparagraph (a) for any line or class of insurance where it can be shown that the information is not needed for that line or class of insurance or where the provision of loss information otherwise is required by law.

(d) Information provided under Subparagraph (b) shall not be subject to discovery by any party other than the insured, the insurer, and the prospective insurer.

(21) The issuance of any line of health insurance in the state by an insurer, self-insurer, or other entity that provides health and accident insurance policies or plans within five years after the entity has ceased writing insurance or issuing plans in the state.

(22) The discrimination against an insured, enrollee, or beneficiary in the issuance, payment of benefits, withholding of coverage, cancellation, or nonrenewal of a policy, contract, plan, or program based upon the results of a prenatal test.

(23) The discrimination against an insured, enrollee, or beneficiary in the issuance, payment of benefits, withholding of coverage, cancellation or nonrenewal of a policy,

contract, plan, or program based upon the results of a genetic test or receipt of genetic information. Actions of an insurer or third parties dealing with an insurer taken in the ordinary course of business in connection with the sale, issuance or administration of a life, disability income, or long-term care insurance policy are exempt from the provisions of this Paragraph.

(24) Requiring an agent or broker or offering any incentive for agents or brokers who represent more than one company to limit information provided to consumers on limited benefit plans. Failure to comply with the provisions of this Paragraph shall subject the insurer to a penalty, of not less than two thousand five hundred dollars nor more than five thousand dollars, payable to the agent or broker and shall not be subject to the penalties provided for in R.S. 22:1969.

(25) Requiring an agent or broker or offering any incentive for agents or brokers, who represent more than one insurance company, to limit the number of other insurance companies they may represent. This prohibition shall not apply to captive insurance agents or brokers. Failure to comply with the provisions of this Paragraph shall subject the insurer to a penalty up to ten thousand dollars and shall not be subject to the penalties provided for in R.S. 22:1969.

Valued Policy

§1318. Valued policy clause; exceptions

A. Under any fire insurance policy insuring inanimate, immovable property in this state, if the insurer places a valuation upon the covered property and uses such valuation for purposes of determining the premium charge to be made under the policy, in the case of total loss the insurer shall compute and indemnify or compensate any covered loss of, or damage to, such property which occurs during the term of the policy at such valuation without deduction or offset, unless a different method is to be used in the computation of loss, in which latter case, the policy, and any application therefor, shall set forth in type of equal size, the actual method of such loss computation by the insurer. Coverage may be voided under said contract in the event of criminal fault on the part of the insured or the assigns of the insured.

B. Any clause, condition, or provision of a policy of fire insurance contrary to the provisions of this Section shall be null and void, and have no legal effect. Nothing contained herein shall be construed to prevent any insurer from cancelling or reducing, as provided by law, the insurance on any property prior to damage or destruction.

C. The liability of the insurer of a policy of fire insurance, in the event of total or partial loss, shall not exceed the insurable interest of the insured in the property unless otherwise provided for by law. Nothing in this Section shall be construed as to preclude the insurer from questioning or contesting the insurable interest of the insured.

D. This Section shall only apply to policies issued or renewed after January 1, 1992, and shall not apply to a loss covered by a blanket-form policy of insurance nor to a loss covered by a builders risk policy of insurance.

Louisiana Insurance Guaranty Association

§2051. Title

This Part shall be known and may be cited as the Louisiana Insurance Guaranty Association Law.

§2052. Purpose

The purpose of this Part is to provide for the payment of covered claims under certain insurance policies with a minimum delay and a minimum financial loss to claimants or policyholders due to the insolvency of an insurer, to provide financial assistance to member insurers under rehabilitation or liquidation, and to provide an association to assess the cost of such operations among insurers.

§2053. Scope; policy coverage determination

A. This Part shall apply to all kinds of direct insurance, except:

(1) Life, annuity, health and accident or disability insurance.

(2) Mortgage guaranty, financial guaranty, or other forms of insurance offering protection against investment risks.

(3) Fidelity or surety bonds, bail bond contracts, or any other bonding obligations.

(4) Credit insurance, vendor's single interest insurance, or collateral protection insurance or any similar insurance which protects the interests of a creditor arising out of a creditor-debtor transaction.

(5) Insurance of warranties or service contracts including vehicle mechanical breakdown insurance or other insurance that provides for the repair, replacement or service for the operational or structural failure of the goods or property due to a defect in materials, workmanship or normal wear and tear, or provides for the liability incurred by the issuer of agreements or service contracts that provide such benefits.

(6) Title insurance.

(7) Ocean marine insurance.

(8) Any transaction or combination of transactions between a person, including affiliates of such person, and an insurer, including affiliates of such insurer, which involves the transfer of investment or credit risk unaccompanied by transfer of insurance risk.

(9) Any insurance provided by or guaranteed by government.

(10) Property residual value insurance.

B. The kind and coverage of insurance afforded by any policy shall be determined solely by the coverage specified and established in the provisions of that policy regardless of any name, label, or marketing designation for the policy.

§2058. Powers and duties of the association

A. The association shall:

(1)(a) Be obliged to pay covered claims pursuant to an order as provided in R.S. 22:2008(C), existing prior to the determination of the insurer's insolvency, or arising after such determination but prior to the first to occur of the following events:

(i) Expiration of thirty days after the date of such determination of insolvency.

(ii) Expiration of the policy.

(iii) Replacement or cancellation of the policy at the instance of the insured if the insured does so within thirty days of such determination.

(b) Satisfy such obligation by paying to the claimant an amount as follows:

(i) The full amount of a covered claim for benefits payable directly to or on behalf of the injured employee or his health care providers, vocational rehabilitation counselors, and similar providers under a workers' compensation insurance coverage.

(ii) An amount not exceeding ten thousand dollars per policy for a covered claim for the return of unearned premium.

(iii) An amount which is in excess of one hundred dollars and is less than five hundred thousand dollars, per claim, subject to a maximum limit of five hundred thousand dollars per accident or occurrence for all other covered claims.

(c)(i) In no event 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. Notwithstanding any other provision of this Part, a "covered claim" shall not include a claim filed with the association after the earlier of five years after the date of the order of liquidation of the insolvent insurer or the final date set by the domiciliary court for the filing of claims against the liquidator or receiver of an insolvent insurer.

(ii) For the purpose of filing a claim under this Subsection, notice of claims to the liquidator of the insolvent insurer shall be deemed notice to the association or its agent

and a list of claims shall be periodically submitted to the association or association similar to the association in another state by the liquidator.

(d) Have no obligation to defend an insured upon the association's payment or tender of an amount equal to the lesser of the association's covered claim obligation limit or the applicable policy limit, or written notice of extinguishment of the obligation due to application of a credit.

(e)(i) Have an applicable limit per claim and per accident or occurrence which shall be exhaustive of the entire liability of the association under this Part, however arising, without regard to the nature of or basis for that liability, except court costs incurred subsequent to the date of insolvency.

(ii) "Accident or occurrence" in this Section means one proximate, uninterrupted, or continuing cause which results in all of the injuries or damages even though several discrete items of damage result, and even though multiple claims and claimants may arise as a result of one such accident or occurrence. A series of claims arising from the same accident or occurrence shall be treated as due to that one accident or occurrence and thus shall be subject to the aggregate liability limit established herein.

(2) To the extent of its obligation on the covered claims, 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.

(3)(a)(i) Assess insurers amounts necessary to pay the obligations of the association under Paragraph (1) of this Subsection subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, and the cost of examinations of the association, to fund loans or provide guarantees to member insurers under rehabilitation or liquidation and other expenses authorized by this Part. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the preceding calendar year, whether or not a company withdraws subsequent to the preceding calendar year, bears to the net direct written premiums of all member insurers for the preceding calendar year. Each member insurer shall be notified of the assessment not later than thirty days before it is due.

(ii) No member insurer may be assessed in any year an amount greater than one percent of that member insurer's net direct written premiums for the preceding calendar year. If the maximum assessment, together with the other assets of the association, does not provide in any one year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon thereafter as funds become available.

(iii) The association may exempt or defer, in whole or in part, the assessment of any member insurer if the assessment would cause the member insurer's financial statement 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.

(iv) The amount of the assessment shall be offset in the same manner that an offset is provided against the premium tax liability in Item (3)(b)(ii) of this Subsection, against the assessment levied by R.S. 22:1476, if such offset shall not be applied against any portion of the assessments to be deposited to the credit of the Municipal Police Employees' Retirement System, the Sheriffs' Pension and Relief Fund, and the Firefighters' Retirement System. To qualify for this offset, the payer shall file a sworn statement with the annual report required by R.S. 22:791 et seq., 821 et seq., and 831 et seq., showing as of December thirty-first of the reporting period that at least the following amounts of the total admitted assets of the payer, less assets in an amount equal to the reserves on its policies issued in foreign countries in which it is authorized to do business and which countries require an investment therein as a condition of doing business, are invested and maintained in qualifying Louisiana investments as defined in R.S. 22:832(C). If one-sixth of the total admitted assets of the payer are in qualifying Louisiana investments, then the offset shall be sixty-six and two-thirds percent of the amount otherwise assessed; if at least one-fifth of the total admitted assets of the payer are in qualifying Louisiana investments, then the offset shall be seventy-five percent of the amount otherwise assessed; if at least one-fourth of the total admitted assets of the payer are in qualifying Louisiana investments, the offset shall be eighty-five percent of the amount otherwise assessed; and if at least one-third of the total admitted assets of the payer are in qualifying Louisiana investments, then the offset shall be ninety-five percent of the amount otherwise assessed. If the total of the net premium tax liability and the assessment for the expenses of the Department of Insurance paid for the previous year was less than the offset allowed under Item (3)(b)(ii) of this Subsection for the previous year, the member company may reduce its assessment payment to the Louisiana Insurance Guaranty Association for the current year by that difference.

(v) An insurer may transfer up to twenty percent annually of any offset as described in this Section with the prior approval of the commissioner to an affiliated insurer. For the purposes of this Section:

(aa) "Affiliated insurer" means an insurance company licensed or holding a certificate of authority to do business in this state which controls, is controlled by, or is under common control with, another insurer.

(bb) "Control" means holding, directly or indirectly, the ownership of or power to vote, at least eighty percent of the voting stock of another member insurer.

(b)(i) Issue to each insurer paying an assessment under this Part a certificate of contribution, in a form prescribed by the commissioner, for the amount so paid. All

outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue.

(ii) A certificate of contribution issued to a member company may be offset against its premium tax liability in an amount not to exceed ten percent of the assessment for the year in which the assessment was paid in full and not to exceed ten percent of the assessment per year for each of the nine calendar years following the year in which such assessment was paid in full, not to exceed a total offset of one hundred percent for each assessment. During the calendar year of issuance of a certificate of contribution, and yearly thereafter, a member shall at its option have the right to show a certificate of contribution as an asset in the form approved by the commissioner at percentages of the original face amount approved by the commissioner, equal to the unused offset as of each such calendar year.

(iii) To the extent amounts have been written off under Item (ii) of this Subparagraph, the provisions of R.S. 22:2066 shall not apply.

(c) Not subject the premium dollars paid to an insurer by any "high net worth insured" as defined in this Part to the assessment provided for in this Section for the next calendar year. Any insurer deducting the premium dollars from its assessment shall provide a net worth affidavit to the association from each insured whose premium dollars are being deducted together with a statement of the amount of premium dollars paid by such insured in accordance with procedures established by the association.

(4) Investigate claims brought against the association and adjust, compromise, settle, and pay covered claims to the extent of the association's obligation and deny all other claims. The association may pay claims in any order that it may deem reasonable, including the payment of claims as they are received from the claimants or in groups or categories of claims. The association shall have the right to appoint and to direct legal counsel retained under liability insurance policies for the defense of covered claims.

(5) Notify claimants, insureds and other interested parties of the determination of insolvency and of their rights under this Part as deemed necessary by the commissioner and upon the commissioner's request, to the extent records are available to the association. The association may discharge this duty by notice mailed to the last known address or notice by publication in a newspaper of general circulation when a mailing address is unavailable or insufficient.

(6)(a) Have the right to review and contest as set forth in this Subsection 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 annul, vacate, or 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, in addition to the defenses available to the insurer:

(i) The association is not bound by an unsatisfied settlement, release, compromise or waiver executed by an insured or the insurer, or any unsatisfied judgment entered against an insured or the insurer by consent or through a failure to exhaust all appeals, if the settlement, release, compromise, waiver or judgment was executed or entered within one hundred twenty 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 executed by or taken against an insured or the insurer based on default, fraud, ill practice, collusion, the insurer's failure to defend, or the clearly excessive amount of any settlement, release, compromise, waiver or judgment considering all relevant issues including but not limited to coverage, liability, and quantum.

(ii) If a court of competent jurisdiction finds that the association is not bound by a settlement, release, compromise, waiver or judgment for the reasons described in Item (i) of this Subparagraph, 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 may not be considered as evidence of liability or damages in connection with any claim brought against the association or any other party under this Part.

(iii) 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.

(b) 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, either on its own behalf or on behalf of an insured, have the right to apply to have the judgment, order, decision, verdict or finding set aside by the same court or administrator that entered the judgment, order, decision, verdict or finding and be permitted to defend the claim on the merits.

(7) Handle claims through its employees or through one or more insurers or other persons designated as servicing facilities. Designation of a servicing facility is subject to the approval of the commissioner, but such designation may be declined by a member insurer.

(8) Reimburse each servicing facility for obligations of the association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the association and shall pay the other expenses of the association authorized by this Part.

(9) Implement a system of alternative dispute resolution of lawsuits and claims.

(10) Coordinate and work in conjunction with the commissioner of insurance, or his designee charged with oversight and implementation of the provisions of this Part.

B. The association may:

(1) Employ or retain such persons as are necessary to handle claims and perform other duties of the association.

(2) Borrow funds necessary to effect the purposes of this Part. In connection therewith the association may agree to such terms and conditions as it deems necessary and proper, and the association may assign to the state or any agency or authority thereof, or to any private entity, the right to the receipt of assessments to the extent necessary to provide for the payment of bonds issued by the state or such agency or authority, or such private agency, for the purpose of providing for the repayment of such borrowings.

(3) Sue or be sued. The power to sue includes the power and right to intervene as a party before any court in this state that has jurisdiction over an insolvent insurer.

(4) Negotiate and become a party to such contracts as are necessary to carry out the purpose of this Part.

(5) Perform such other acts as are necessary or proper to effectuate the purpose of this Part.

(6) Refund to the member insurers in proportion to the contribution of each member insurer to the association that amount by which the assets of the association exceed the liabilities, if, at the end of any calendar year, the board of directors finds that the assets of the association exceed the liabilities of the association as estimated by the board of directors for the coming year.

(7) Submit with the commissioner to the court having jurisdiction over an impaired or insolvent insurer a joint written plan of full or partial rehabilitation or liquidation that satisfies the court that such plan is the most cost-effective method of addressing the member insurer's impairment or insolvency, is in the best interest of the member insurer's policyholders and claimants and is in the best interests of the association, and may, upon approval of the court:

(a) Guarantee, assume, or cause to be guaranteed or assumed, including the financial undertakings necessary and proper to effect such guarantees or assumptions, any or all of the policies, contracts, or other obligations of such member insurer.

(b) Lend money to such member insurer.

C. Suits involving the association:

(1) Except for actions by the receiver, all actions relating to or arising out of this Part against the association shall be brought in the courts in this state. The courts shall have exclusive jurisdiction over all actions relating to or arising out of this Part against the association.

(2) The domicile of the association for purposes of venue is East Baton Rouge Parish. The association may, at its option, waive exceptions to venue for specific actions.

(3) Any person, and any attorney who represents a person, who files a petition against the association alleging as a basis for the claim the insolvency of an insurer, where said insurer is not an insolvent insurer within the meaning of this Part, shall pay the reasonable expenses incurred because of the filing of the petition, including a reasonable attorney fee, subject to the following conditions:

(a) The association shall furnish to either the person or his attorney, by ordinary service of process, hand delivery, or certified mail, return receipt requested, written notification that the insurer is not an insolvent insurer within the meaning of this Part.

(b) If, within sixty days of the receipt of such notification, the person or his attorney has not dismissed the petition, with prejudice and at plaintiff's cost.

D.(1) Notwithstanding any other provision to the contrary and unless such other law is specifically excepted from this Section, the provisions of this Section shall supersede and prevail over any other law to the contrary.

(2) This Section shall not apply to R.S. 24:38(C) and 654.

§2061. Effect of paid claims

A. Any person recovering under this Part shall be deemed to have assigned his rights under the policy to the association to the extent of his recovery from the association. Every insured or claimant seeking the protection of this Part shall cooperate with the association to the same extent as such person would have been required to cooperate with the insolvent insurer. The association shall have no cause of action against the insured of the insolvent insurer for any sums it has paid out except such causes of action as the insolvent insurer would have had if such sums had been paid by the insolvent insurer, except with respect to the recovery of sums paid on a claim excluded due to the high net worth of an insured as defined in this Part. In the case of an insolvent insurer operating on a plan with assessment liability, payments of claims of the association shall not operate to reduce the liability of insureds to the receiver, liquidator or statutory successor for unpaid assessments.

B. 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 court having jurisdiction shall grant such claims priority equal to that which the claimant would have been entitled in the absence of this Part against the assets of the insolvent insurer. The expenses of the association or similar organization in handling claims shall be accorded the same priority as the liquidator's expenses.

C. 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.

D. The association and any association similar to the association in another state shall be entitled to file a claim in the liquidation of an insolvent insurer for any amounts paid by them on covered claim obligations as determined under this Part or similar laws in other states and shall receive dividends and other distributions at the priority set forth in R.S. 22:2025.

§2061.1. Net worth exclusion

A. For purposes of this Part, "high net worth insured" shall mean any policyholder or named insured, other than any state or local governmental agency or subdivision thereof, whose net worth exceeds twenty-five million dollars on December thirty-first of the year prior to the year in which the insurer becomes an insolvent insurer if an insured's net worth 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. The consolidated net worth of the insured and all of its affiliates shall be calculated on the basis of their fair market values. The members of a group self-insurance fund formed pursuant to R.S. 23:1191 et seq. shall not be deemed to be affiliates of the fund, and shall not be included in the determination of the net worth of the fund. For the purposes of this Section, a group self-insurance fund, and each individual member of the fund upon whose behalf a claim is submitted, shall be deemed to be policyholders or named insureds of any policy of insurance issued to the fund.

B.(1) The association shall not be obligated to pay any claims or provide a defense to any claims asserted for coverage under a policy when the insured is a high net worth insured.

(2) The association shall have the right to recover from a high net worth insured all costs incurred and all amounts paid by the association to or on behalf of such insured, whether for indemnity, defense or otherwise, including attorney fees, administrative costs, court costs, settlement, or other defense costs.

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 that state's applicable law, and which association has denied coverage to that claimant on that basis.

D. The association shall establish reasonable procedures subject to the approval of the commissioner 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 must 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 such 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.

§2062. Exhaustion of other coverage

A.(1) Any person having a claim against an insurer shall be required first to exhaust all coverage provided by any other policy, including the right to a defense under the other policy, if the claim under the other policy arises from the same facts, injury or loss that gave rise to the covered claim against the association. The requirement to exhaust shall apply without regard to whether or not 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 or annuity.

(2) Any amount payable on a covered claim under this Part shall be reduced by the full applicable limits stated in the other insurance policy, or by the amount of the recovery under the other insurance policy as provided herein. The association and the insured 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 other insurance policy, or if there are no applicable stated limits under the policy, the association and the insured shall receive a full credit for the total recovery.

(a) The credit shall be deducted from the lesser of the following:

(i) The association's covered claim limit.

(ii) The amount of the judgment or settlement of the claim.

(iii) The policy limits of the policy of the insolvent insurer.

(b) In no case, however, shall the obligation of the association exceed the covered claim limit of this Part.

(3) If the insured or claimant has a contractual right to claim defense under an insurance policy issued by another insurer, including a self-insurer, the insured or claimant shall first exhaust all rights to indemnity and defense under such policy before claiming indemnity or defense from the association, or the insured of the insolvent insurer. The association's duty to defend under the policy issued by the insolvent insurer is subject to any other limitation on the duty to defend in this Part. This duty is secondary to the obligation of any other insurer or self-insurer to provide a defense, whose duty to the claimant is primary.

(4) A claim under a policy providing liability coverage to a person who may be solidarily liable as a tortfeasor with the person covered under the policy of the insolvent insurer that gives rise to the covered claim shall be considered to be a claim arising from the same facts, injury or loss that gave rise to the covered claim against the association.

(5) For purposes of this Section, a claim under an insurance policy other than a life insurance policy or annuity shall include, but is not limited to:

(a) A claim against a health maintenance organization, a hospital plan corporation, a professional health service corporation or disability insurance policy, liability coverage, uninsured or underinsured motorist liability coverage, hospitalization, coverage under self-insurance certificates, preferred provider organization, or similar plan, and any and all other medical expense coverage.

(b) Any amount payable by or on behalf of a self-insurer.

(c) Any claim against persons prohibited from recovering against the association as specified in this Part.

(6) In the case of a claimant alleging personal injury or death caused by exposure to asbestos fibers or other claim resulting from exposure to, release of, or contamination from any environmental pollutant or contaminant, any and all other insurance available to the insured for the claim for all policy periods for which insurance is available must first be exhausted before recovering from the association, even if an insolvent insurer provided the only coverage for one or more policy periods of the alleged exposure. Only after exhaustion of all solvent insurer's total policy aggregate limits for any alleged exposure periods will the association be obligated to provide a defense and indemnification within the obligations of this Part, subject to a credit for the total amount thereof, whether or not the total amount has actually been paid or recovered.

B. Any person having a claim which may be recovered under more than one insurance guaranty association or its equivalent shall seek recovery first from the association of the place of residence of the insured except that if it is a first party claim for damage to property with a permanent location, he shall seek recovery first from the association of the location of the property, and if it is a workers' compensation claim, he shall seek recovery first from the association of the residence of the claimant. For purposes of this Section, the "residence of the insured" shall be the residence, on the date of insolvency

of the insurer or self-insurer, of the first named or primary insured or the state to which the insolvent insurer or self-insurer was or would have been liable for the payment of a surcharge or assessment on the subject insurance policy to an insurance guaranty association or its equivalent. A claimant alleging personal injury or death caused by exposure to asbestos fibers or other claim resulting from exposure to, release of, or contamination from any environmental pollutant or contaminant, asserted against the association must either be a domiciliary of the state of Louisiana at the time of the exposure or allege that his exposure to asbestos or other environmental hazard, which is a substantial contributing factor to the physical impairment upon which the claim is based, occurred in Louisiana. Where more than one claimant is joined, each claimant must independently establish that Louisiana is either his domicile or place in which the alleged exposure occurred.

C. Any recovery under this Part by any claimant not a resident of the state of Louisiana at the time such claim arose, shall not exceed the lesser of the recovery allowed under this Part or that payable by the insurance guaranty association or its equivalent in the claimant's state of residence. As to the association, any amount payable by the other guaranty association or its equivalent shall act as a credit against the damages of the claimant, and the association shall not be liable for that portion of the damages of the claimant.

D. The association shall have no duty to provide a separate defense at its cost to an insured of an insolvent insurer as to any issue arising out of the coverage of this Section.

§2069. Advertisements

A. Advertisements which include a reference to the coverage or protection by the Louisiana Insurance Guaranty Association are specifically prohibited.

B. As used in this Section, "advertisements" means any communication by print, television, radio, Internet, or other means for mass distribution of information.

C.(1) Whoever violates this Section shall, upon conviction, be fined not less than five hundred dollars nor more than one thousand dollars for a first offense, and not less than one thousand dollars nor more than two thousand dollars for a second offense.

(2) Conviction for violations of this Section as a second offense shall be grounds for suspension or revocation of the license of the violator by the commissioner.

Automobile Cancellation

§1266. Automobile, property, casualty, and liability insurance policies; cancellations

A. As used in this Part:

(1) "Policy" means an automobile liability, automobile physical damage, or automobile collision policy, or any combination thereof, delivered or issued for delivery in this state, or any binder based on such a policy, insuring a single individual or husband and wife resident of the same household, as named insured, and under which the insured vehicles therein designated are of the following types only:

(a) A private passenger vehicle that is not used as a public or livery conveyance for passengers, nor rented to others.

(b) Any other four-wheel motor vehicle with a load capacity of sixteen hundred pounds or less which is not used in the occupation, profession or business of the insured; however, this shall not apply to:

(i) Any policy issued under an automobile assigned risk plan.

(ii) Any policy insuring more than four automobiles.

(iii) Any policy covering garage, automobile sales agency, repair shop, service station, or public parking place operation hazards.

(2) "Automobile liability coverage" includes only coverages of bodily injury and property damage liability, medical payments and uninsured motorists coverage.

(3) "Automobile physical damage coverage" includes all coverage of loss or damage to an automobile insured under the policy except loss or damage resulting from collision or upset.

(4) "Automobile collision coverage" includes all coverage of loss or damage to an automobile insured under the policy resulting from collision or upset.

(5) "Renewal" or "to renew" means the issuance and delivery by an insurer of a policy replacing at the end of the policy period a policy previously issued and delivered by the same insurer, or the issuance and delivery of a certificate or notice extending the term of a policy beyond its policy period or term. However, no policy of insurance for a period of less than six months shall be issued by an insurer to any person who has been issued two or more citations for violations of R.S. 32:851 et seq. or R.S. 32:861 et seq., and any policy issued to a person receiving two or more citations shall be considered as if written for a policy period or term of six months. Any policy which is

written for a term longer than one year or any policy which is renewed by an insurer shall be for the same term as the original or expired policy, or any policy with no fixed expiration date shall for the purpose of this Subpart be considered as if written for successive policy periods or terms of one year. Such a policy may be terminated at the expiration of any annual period upon giving twenty days notice of cancellation prior to such anniversary date. This cancellation shall not be subject to any other provisions of this Subpart.

(6) "Nonpayment of premium" means failure of the named insured to discharge when due any of his obligations in connection with the payment of premiums on a policy, or any installment of such premium, whether the premium is payable directly to the insurer or its agent or indirectly under any premium finance plan or extension of credit.

B.(1) A notice of cancellation of a policy shall be effective only if it is based on one or more of the following reasons:

(a) Nonpayment of premium.

(b) The driver's license or motor vehicle registration of the named insured or of any other operator who either resides in the same household or customarily operates an automobile insured under the policy has been under suspension or revocation during the policy period, or, if the policy is a renewal, during its policy period or the one hundred eighty days immediately preceding its effective date.

(c) Fraud or material misrepresentation in the presentation of a claim.

(d) Nonreceipt by the insurer of an application for insurance in which a valid binder has been issued.

(2) This Subsection shall not apply to nonrenewal or to any policy or coverage which has been in effect less than sixty days at the time notice of cancellation is mailed or delivered by the insurer unless it is a renewal policy. After an insurer has paid and satisfied an insured's third physical damage claim within a period of five years, the modification of such insured's automobile physical damage coverage by the inclusion of or a change in a deductible not exceeding five hundred dollars shall not be deemed a cancellation of the coverage or of the policy.

C. No insurer shall cancel or fail to renew a policy purely because of age. Some legitimate reason, such as physical or mental infirmity, must be specified before an insurer may cancel or refuse to renew a policy.

D.(1) No notice of cancellation of a policy to which Subsection B or C of this Section applies shall be effective unless mailed by certified mail or delivered by the insurer to the named insured at least thirty days prior to the effective date of cancellation; however, when cancellation is for nonpayment of premium at least ten days notice of cancellation accompanied by the reason shall be given. In the event of nonpayment of

premiums for a binder, a ten-day notice of cancellation shall be required before the cancellation shall be effective. Notice of cancellation for nonpayment of premiums shall not be required to be sent by certified mail. Unless the reason accompanies the notice of cancellation, the notice of cancellation shall state or be accompanied by a statement that upon written request of the named insured, mailed or delivered to the insurer within six months after the effective date of cancellation, the insurer will specify the reason for such cancellation. This Subsection shall not apply to nonrenewal.

(2) There shall be no liability and no cause of action of any nature against any insurer or its producers, employees, or representatives for any action taken by them to provide the reasons for cancellation as required by this Subsection.

(3)(a)(i) Payment of an initial, renewal, or installment insurance premium by the insured to an insurer or a producer with a check or other negotiable instrument which is returned to the payee by the institution upon which it is drawn for insufficient funds available in the account, for lack of credit, for the reason the account is closed, for stopped payment, or for any other reason shall be deemed grounds for the insurer to cancel the binder or policy from the date the premium payment was due for the initial or renewal term, whichever is applicable.

(ii) The provisions of this Paragraph shall apply to automobile liability policies and to property, casualty, and liability policies.

(b)(i) The producer shall immediately, and in no case later than ten days after the producer or premium finance company has received notice of the returned check or negotiable instrument, notify the insurer of the receipt of the returned check or negotiable instrument.

(ii) The insurer shall immediately, and in no case later than ten days after the producer or premium finance company has notified the insurer, notify the named insured, by certified mail or delivering to the named insured a written notice that the policy is canceled from the date the premium payment was due. The insurer shall advise the named insured that the policy shall be reinstated effective from the date the premium payment was due for the term of the policy only if the named insured or his legal representative presents to the insurer a cashier's check or money order for the full amount of the returned check or other negotiable instrument within ten days of the date that the notice of cancellation was mailed.

(c) Upon expiration of the ten-day period, either:

(i) The insurer shall reinstate the insured's policy, from the date that the premium was due, and shall pay directly to the producer all funds paid to the insurer by the insured or his legal representative to replace the dishonored check or other negotiable instrument.

(ii) Cancellation of the policy shall remain effective, when the insured or his legal representative has failed to redeem the dishonored check or other negotiable instrument before expiration of the ten-day period.

(d)(i) Within ten days of the expiration of the ten-day notice, the insurer shall return all funds paid by the producer to the insurer on behalf of the insured except when an insurance premium finance company has funded an insured's policy, the insurer shall return those funds directly to the insurance premium finance company. These funds shall be returned by check or other negotiable instrument and shall not be placed on the producer's or premium finance company's account currents unless the producer or premium finance company and the insurer have agreed to other methods for handling these funds. Funds received by the insurance premium finance company in excess of the amount funded by the insurance premium finance company shall be forwarded to the producer.

(ii) The original or a copy of the returned dishonored check or negotiable instrument, front and back, mailed or faxed, to the insurance company shall be proof of the returned dishonored check or negotiable instrument by the financial institution and shall be considered sufficient evidence in any future litigation.

(iii) When an insured pays the dishonored check by delivery to the producer of cash or a certified check, the producer shall notify the insurer within ten days of the payment of the dishonored check.

(e) In the event the policy has been canceled back to the date of inception or premium payment due in accordance with this Paragraph, the sixty-day periods referred to in R.S. 9:3550(H) and R.S. 22:887(F) shall not apply. The funds shall be returned by the insurer by check within ten days of the expiration of the ten-day notice of cancellation.

(4)(a) In the event that a producer incorrectly states the premium amount for the automobile liability policy, the insured may cancel the policy and shall be returned the initial payment of premium, including fees and costs, less the prorated cost for the period of time of coverage at the initial stated premium, including fees and costs, and may cancel the insurance coverage, without penalty or loss of coverage, for the period of time that the premium, including fees and costs, was paid.

(b) When an insurance premium finance company has funded an insured's policy and the policy is cancelled, the insurer shall return the funds directly to the insurance premium finance company. Any funds received by the insurance premium finance company in excess of the amount owed to the insurance premium finance company by the insured shall be forwarded to the producer to be returned to the insured. The insurer shall not withhold any more funds from the insurance premium finance company than would otherwise be withheld from the insured. No insurer shall assess a service charge for this transaction.

E.(1) No insurer shall fail to renew a policy unless it shall mail or deliver to the named insured, at the address shown in the policy, at least twenty days advance notice of its intention not to renew. This Subsection shall not apply:

(a) If the insurer has manifested its willingness to renew.

(b) In case of nonpayment of premium; however, notwithstanding the failure of an insurer to comply with this Subsection, the policy shall terminate on the effective date of any other insurance policy with respect to any automobile designated in both policies.

(c) If the insurer or a company within the same group as the insurer has offered to issue a renewal policy to the named insured.

(d) If the named insured has provided written notification to the insurer of the insured's intention not to renew the policy.

(2) Renewal of a policy shall not constitute a waiver or estoppel with respect to grounds for cancellation which existed before the effective date of such renewal.

(3) Upon the written request of the named insured, the insurer shall provide to the insured in writing the reasons for nonrenewal of the policy. There shall be no liability and no cause of action of any nature against any insurer or its producers, employees, or representatives for any action taken by them to provide the reasons for nonrenewal as required by this Paragraph.

F. Proof of mailing of notice of cancellation, or of intention not to renew or of reasons for cancellation, to the named insured at the address shown in the policy, shall be sufficient proof of notice.

G. When a policy of automobile liability insurance is cancelled, other than for nonpayment of premium, or in the event of failure to renew a policy of automobile liability insurance to which Subsection D applies, the insurer shall notify the named insured of his possible eligibility for automobile liability insurance through the automobile liability assigned risk plan. Such notice shall accompany or be included in the notice of cancellation or the notice of intent not to renew.

H. Repealed by Acts 1987, No. 510, §2.

I. There shall be no liability and no cause of action of any nature against the commissioner of insurance or against any insurer, its authorized representative, its producers, its employees, or any firm, person, or corporation furnishing to the insurer information as to reasons for cancellation, for any statement made by any of them in any written notice of cancellation, or in any other communication, oral or written, specifying the reasons for cancellation, or the providing of information pertaining thereto, or for statements made or evidence submitted at any hearings conducted in connection therewith.

J. Where written notice of cancellation or nonrenewal is required and the insurer elects to mail the notice, the running of the time period between the date of mailing and the effective date of termination of coverage shall commence upon the date of mailing.

K. No insurer shall cancel an automobile insurance policy written or issued for delivery in this state belonging to an insured over the age of sixty-five based upon the age of the insured provided the insured is mentally and physically capable of driving an automobile and possesses a valid Louisiana operator's license issued by the office of motor vehicles of the Louisiana Department of Public Safety and Corrections.

L. No insurer shall cancel an automobile insurance policy for any insured solely on the ground that the insured has submitted a single claim under the policy for damage incurred or arising from the operation of an automobile. The provisions of this Subsection shall not prohibit an insurer from increasing the cost of the insured's premium based on the number of claims submitted under the policy for damage incurred or arising from the operation of an automobile. For the purposes of this Subsection, an incident shall be deemed a claim only when there is a demand for payment under the terms of the policy. A report of loss or a question relating

Homeowners Cancellation

§1335. Homeowner's insurance; cancellation, nonrenewal

A. An insurer that has issued a policy of homeowner's insurance shall not fail to renew the policy unless it has mailed or delivered to the named insured, at the address shown in the policy, written notice of its intention not to renew. The notice of nonrenewal shall be mailed or delivered at least thirty days before the expiration date of the policy. If the notice is mailed less than thirty days before expiration, coverage shall remain in effect under the terms and conditions until thirty days after the notice is mailed or delivered. Any earned premium for the period of coverage extended beyond the expiration date shall be considered pro rata based upon the rate of the previous year.

B. The 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 provided written notification to the insurer of the intention of the insured not to renew.

§1265. Property, casualty, and liability insurance policies; cancellation and nonrenewal provisions; nonrenewal for rate inadequacy; certain prohibitions

A.(1) Any insurer cancelling or refusing to renew a policy providing property, casualty, or liability insurance on any property shall, upon written request of the policy's named insured, specify in writing the reason or reasons for such cancellation or refusal to renew. Such request shall be mailed or delivered to the insurer within six months after the effective date of cancellation or expiration.

(2) There shall be no liability and no cause of action of any nature against any insurer or its producers, employees, or representatives for any action taken by them to provide the reasons for cancellation as required by this Subsection.

(3) Any nonrenewal for which the reason, in whole or in part, is inadequacy or insufficiency of the rate or premium for coverage shall be permitted only after the insurer has sought actuarially justified rate relief from the commissioner of insurance and such rate relief has been rejected by the commissioner.

B. There shall be no liability and no cause of action of any nature against the commissioner of insurance or against any insurer, its authorized representative, its producers, its employees, or any firm, person, or corporation furnishing to the insurer information as to reasons for cancellation or refusal to renew, or in any other communication, oral or written, specifying the reasons for cancellation or refusal to

renew, or the providing of information pertaining thereto, or for statements made or evidence submitted at any hearings conducted in connection therewith.

C. No insurer providing property, casualty, or liability insurance shall cancel or refuse to issue or fail to renew a homeowner's policy solely on the basis that the insured owns or possesses an all-terrain vehicle (ATV). The provisions of this Subsection shall not prohibit an insurer providing property, casualty, or liability insurance from specifically excluding coverage for damage incurred or arising from the operation of an all-terrain vehicle.

D. No insurer providing property, casualty, or liability insurance shall cancel or fail to renew a homeowner's policy of insurance or to increase the policy deductible that has been in effect and renewed for more than three years unless based on nonpayment of premium, fraud of the insured, a material change in the risk being insured, two or more claims within a period of three years, or if continuation of such policy endangers the solvency of the insurer. This Subsection shall not apply to an insurer that ceases writing homeowner's insurance or to policy deductibles increased for all homeowners' policies in the state. For the purposes of this Subsection, an incident shall be deemed a claim only when there is a demand for payment by the insured or the insured's representative under the terms of the policy. A report of a loss or a question relating to coverage shall not independently establish a claim. As used in this Subsection, the phrase "two or more claims within a period of three years" shall not include any loss incurred or arising from an "Act of God" incident which is due directly to forces of nature and exclusively without human intervention.

E. The department shall review annually every insurer that cancels or fails to renew any insurance policy providing property, casualty, or liability insurance on any property which policy has been in effect and renewed for more than three years when the cancellation or nonrenewal is based on the reason that continuation of the policy endangers the solvency of the insurer or when based on the reason, in whole or in part, of inadequacy or insufficiency of the rate or premium for coverage after the insurer has sought actuarially justified rate relief from the commissioner and such relief has been rejected by the commissioner. Any action against an insurer taken by the department for a violation of the provisions of this Section shall remain in effect until changed or modified by the commissioner based upon the review required under the provisions of this Subsection.

F. Notwithstanding the provisions of Subsection D of this Section, an insurer may make a filing with the commissioner pursuant to R.S. 22:1464 for authorization to deviate from the provisions of Subsection D of this Section for the sole purpose of changing the policy deductible to a total deductible of not more than four percent of the value of the property being insured for named storms or hurricanes on a homeowner's policy of insurance that has been in effect for more than three years. Any insurer filing with the commissioner pursuant to this Subsection shall file with the commissioner a business plan setting forth the insurer's plan to write new business in the particular region or area of the state in which the new deductible is to apply. The commissioner's approval is to

be based on the insurer's commitment to the writing of new business in the respective region or area of the state in which the new deductible is to apply. The commissioner may also approve a filing that he determines to be in the best interest of the policyholders. The commissioner may subsequently rescind his approval of any filing made pursuant to this Subsection in the event the insurer fails to write new business in accordance with the business plan. Any business plan filed shall be considered proprietary or trade secret pursuant to information under the provisions of R.S. 44:3.2 and the Uniform Secrets Act. The commissioner shall provide an annual report to the legislative committees on insurance on the application and effectiveness of the provisions of this Section. The commissioner shall promulgate regulations pursuant to the Administrative Procedure Act setting forth the criteria for the filing, including any financial or other requirements that he deems necessary to act on the request by an insurer. Any regulation promulgated by the commissioner pursuant to this Subsection shall require the insurer to itemize to the insured the premium savings based on the increase in the insured's deductible.

G. No homeowner's policy of insurance shall contain any provision that would apply more than one deductible to a loss resulting from any single incident covered by the policy. Any such provision shall be null and void and unenforceable as contrary to public policy.

H. Any company which makes a filing pursuant to Subsection F of this Section shall reduce the rates paid by the individual homeowner by the amount determined to be actuarially justified by the commissioner.

§1336. Homeowner's insurance; acts of God

No insurer shall cancel, fail to renew, or increase the amount of the premium, except upon an area-wide rating basis at the beginning of a new policy period, on a homeowner's policy of insurance based solely upon a loss caused by an "Act of God". An "Act of God" shall mean, in this Section, an incident due directly to natural causes and exclusively without human intervention.

Commercial Cancellation

§1267. Commercial insurance; cancellation and renewal

A. This Section shall apply to commercial property insurance policies, commercial automobile insurance policies, commercial multi-peril insurance policies, workers' compensation insurance, professional errors and omissions policies, and commercial liability insurance policies, other than aviation and employers' liability insurance policies. It shall not apply to reinsurance, excess and surplus lines insurance, residual market risks, multistate location risks, policies subject to retrospective rating plans, excess or umbrella policies, and such other policies that are exempted by the commissioner of insurance.

B. For the purposes of this Section, the following terms shall mean:

(1) "Cancellation" means termination of a policy at a date other than its expiration date.

(2) "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 year or with no fixed expiration date, each annual anniversary date of such policy.

(3) "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 regulation, whether such payments are payable directly to the insurer or its producer or indirectly payable under a premium finance plan or extension of credit.

(4) "Nonrenewal" means termination of a policy at its expiration date.

(5) "Renewal" or "to renew" means the issuance of or the offer to issue by the insurer 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.

C.(1) If coverage has not been in effect for sixty days and the policy is not a renewal, cancellation shall be effected by mailing or delivering a written notice to the first-named insured at the mailing address shown on the policy at least sixty days before the cancellation effective date, except in cases where cancellation is based on nonpayment of premium. Notice of cancellation based on nonpayment of premium shall be mailed or delivered at least ten days prior to the effective date of cancellation. After coverage has been in effect for more than sixty days or after the effective date of a renewal policy, no insurer shall cancel a policy unless the cancellation is based on at least one of the following reasons:

(a) Nonpayment of premium.

(b) Fraud or material misrepresentation made by or with the knowledge of the named insured in obtaining the policy, continuing the policy, or in presenting a claim under the policy.

(c) Activities or omissions on the part of the named insured which change or increase any hazard insured against, including a failure to comply with loss control recommendations.

(d) Change in the risk which increases the risk of loss after insurance coverage has been issued or renewed, including an increase in exposure due to regulation, legislation, or court decision.

(e) Determination by the commissioner of insurance that the continuation of the policy would jeopardize a company's solvency or would place the insurer in violation of the insurance laws of this state or any other state.

(f) Violation or breach by the insured of any policy terms or conditions.

(g) Other reasons that are approved by the commissioner of insurance.

(2)(a) A notice of cancellation of insurance coverage by an insurer shall be in writing and shall be mailed or delivered to the first-named insured at the mailing address as shown on the policy. Notices of cancellation based on R.S. 22:1267(C)(1)(b) through (g) shall be mailed or delivered at least thirty days prior to the effective date of the cancellation; notices of cancellations based upon R.S. 22:1267(C)(1)(a) shall be mailed or delivered at least ten days prior to the effective date of cancellation. The notice shall state the effective date of the cancellation.

(b) The insurer shall provide the first-named insured with a written statement setting forth the reason for the cancellation where the insured requests such a statement in writing and the named insured agrees in writing to hold the insurer harmless from liability for any communication giving notice of or specifying the reasons for a cancellation or for any statement made in connection with an attempt to discover or verify the existence of conditions which would be a reason for cancellation under this regulation.

(3) Nothing in this Section shall require an insurer to provide a notice of cancellation or a statement of reasons for cancellation where cancellation for nonpayment of premium is effected by a premium finance agency or other entity pursuant to a power of attorney or other agreement executed by or on behalf of the insured.

D.(1) An insurer may decide not to renew a policy if it delivers or mails to the first-named insured at the address shown on the policy written notice it will not renew the policy. Such notice of nonrenewal shall be mailed or delivered at least sixty days before

the expiration date. Such notice to the insured shall include the insured's loss run information for the period the policy has been in force within, but not to exceed, the last three years of coverage. If the notice is mailed less than sixty days before expiration, coverage shall remain in effect under the same terms and conditions until sixty days after notice is mailed or delivered. 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 shall not be a refusal to renew. In addition, changes in the deductible, changes in rate, changes in the amount of insurance, or reductions in policy limits or coverage shall not be refusals to renew.

(2) 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 where the named insured has obtained replacement coverage or has agreed in writing to obtain replacement coverage.

(3) If an insurer provides the notice described in Paragraph (1) of this Subsection and thereafter the insurer extends the policy for ninety days or less, an additional notice of nonrenewal is not required with respect to the extension.

E.(1) An insurer shall mail or deliver to the named insured at the mailing address shown on the policy written notice of any rate increase, change in deductible, or reduction in limits or coverage at least thirty days prior to the expiration date of the policy. If the insurer fails to provide such thirty-day notice, the coverage provided to the named insured at the expiring policy's rate, terms, and conditions shall remain in effect until notice is given or until the effective date of replacement coverage obtained by the named insured, whichever first occurs. For the purposes of this Subsection, notice is considered given thirty days following date of mailing or delivery of the notice. 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.

(2) This Subsection shall not apply to the following:

(a) Changes in a rate or plan filed with the commissioner of insurance and applicable to an entire class of business.

(b) Changes based upon the altered nature or extent of the risk insured.

(c) Changes in policy forms filed and approved with the commissioner and applicable to an entire class of business.

(d) Changes requested by the insured.

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.

Surplus Lines Cancellation

OFFICE OF THE COMMISSIONER OF INSURANCE
STATE OF LOUISIANA

ADVISORY LETTER NUMBER 02-01
June 24, 2002

TO: ALL PROPERTY AND CASUALTY INSURERS APPROVED TO ISSUE POLICIES INSURING RISKS IN LOUISIANA

RE: NOTICE OF CANCELLATION - NOTICE OF NONRENEWAL

STATUTE AND REGULATION REFERENCES:
Title 22 of the Louisiana Revised Statutes §§ 2, 1211 et seq., and 1262.1

It has come to the attention of the Commissioner that surplus lines insurers are canceling and/or non-renewing insurance policies with little or no notice to the insured. Please be advised that the Commissioner finds that such conduct is not in the best interest of the policyholders or the citizens of Louisiana.

Pursuant to LRS 22:1262.2 a surplus lines insurer may be removed from the list of approved unauthorized insurers if the Commissioner finds that it is not in the best interest of policyholders or the citizens of Louisiana for the insurer to be allowed to continue to do business in this state.

Unapproved insurers doing business in Louisiana should take note that the surplus lines market in the state is much broader than in other states. Indeed, the surplus lines market competes directly with the admitted market for many lines and/or classes of business. Therefore, the manner in which such insurers conduct business is of greater concern than might otherwise exist if the market were more limited.in scope.

Surplus lines insurers are hereby advised that they should make every effort to give reasonable notice to their policyholders prior to canceling or non-renewing an insurance policy or risk removal from our white list. It is the opinion of the Commissioner that a minimum of thirty (30) days is reasonable, unless the cancellation is for non-payment of premium, in which case notice of not less than ten (10) days would be reasonable as called for in LSA-R.S. 22:636 for admitted insurers.

Any questions regarding this Advisory Letter may be directed to Ms. Kathlee Hennigan, Director of the Property and Casualty Division, at khennigan@ldi.state.la.us or by telephone at 225-342-0073 or to C. Noel Wertz Chief Attorney, Property and Casualty Section at nwertz@ldi.state.la.us. or by telephone at 225-342-4632.

J. ROBERT WOOLEY
ACTING COMMISSIOER OF INSURANCE

Workers Compensation – Covered Employees and Exemptions

R.S. 23:1035

§1035. Employees covered

A. The provisions of this Chapter shall also apply to every person performing services arising out of and incidental to his employment in the course of his own trade, business, or occupation, or in the course of his employer's trade, business, or occupation, except that the bona fide president, vice president, secretary, or treasurer of a corporation who owns not less than ten percent of the stock therein, or a partner with respect to a partnership employing him, or a member of a limited liability company as defined in R.S. 12:1301(A)(13) who owns not less than a ten percent membership interest therein, or a sole proprietor with respect to such sole proprietorship may by written agreement with his insurer or group self-insurance fund elect not to be covered by the provisions of this Chapter. Such election shall not be limited, but shall apply to all trades, businesses, or occupations conducted by said corporation, partnership, limited liability company, or sole proprietorship. Such an election shall be binding upon the employing corporation, partnership, limited liability company, and sole proprietor and the surviving spouse, relatives, personal representative, heirs, or dependents of the officer, partner, member, or sole proprietor so electing. No salary or compensation received by any such bona fide corporate officer, partner, member, or sole proprietor so electing shall be used in computing the premium rate for workers' compensation insurance.

B.(1) There is exempt from coverage under this Chapter all labor, work, or services performed by any employee of a private residential householder in connection with the private residential premises of such householder or any employee of a private unincorporated farm, in connection with cultivating the soil, or in connection with raising or harvesting of any agricultural commodity, including the management of livestock, when the employee's annual net earnings for labor, work, or services amounts to one thousand dollars or less and the total net earnings of all employees of such farm do not exceed two thousand five hundred dollars and which labor, work, or services are not incidental to and do not arise out of any trade, business, or occupation of such householder or private unincorporated farm. With respect to such labor, work, or services and any employee performing the same, a private residential householder or a private unincorporated farmer, shall have no liability under the provisions of this Chapter either as employer or as a principal; however, any person who is engaged in the trade, business, or occupation of furnishing labor, work, or services to private residential premises or farms, shall be liable under the provisions of this Chapter to his employees or their dependents for injury or death arising from and incidental to their employment in rendering such labor, work, or services.

(2) There is also exempt from coverage under this Chapter, musicians and performers who are rendering services pursuant to a performance contract.

C. Where applicable, an employee may seek tort recovery for injuries arising out of such labor, work, or services, or recovery from any insurance policy that the homeowner or employer may have which extends coverage to persons injured on the homeowner's or employer's premises, regardless of the employee's employment status, provided that the labor, work, or services performed by such employee are exempt from the provisions of this Chapter.

Amended by Acts 1975, No. 583, §1, eff. Sept. 1, 1975; Acts 1976, No. 177, §1; Acts 1979, No. 465, §1; Acts 1981, No. 827, §1; Acts 1983, 1st Ex. Sess., No. 1, §6; Acts 1995, No. 246, §1, eff. June 14, 1995; Acts 1997, No. 920, §1, eff. July 10, 1997; Acts 2001, No. 1014, §1, eff. June 27, 2001; Acts 2001, No. 1100, §1; Acts 2010, No. 120, §1.

R.S. 23:1035.1

§1035.1. Extraterritorial coverage

(1) If an employee, while working outside the territorial limits of this state, suffers an injury on account of which he, or in the event of his death, his dependents, would have been entitled to the benefits provided by this Chapter had such injury occurred within this state, such employee, or in the event of his death resulting from such injury, his dependents, shall be entitled to the benefits provided by this Chapter, provided that at the time of such injury

(a) his employment is principally localized in this state, or

(b) he is working under a contract of hire made in this state.

(2) The payment or award of benefits under the workers' compensation law of another state, territory, province, or foreign nation to an employee or his dependents otherwise entitled on account of such injury or death to the benefits of this Chapter shall not be a bar to a claim for benefits under this act; provided that claim under this act is filed within the time limits set forth in R.S. 23:1209. If compensation is paid or awarded under this act:

(a) The medical and related benefits furnished or paid for by the employer under such other worker's compensation law on account of such injury or death shall be credited against the medical and related benefits to which the employee would have been entitled under this act had claim been made solely under this act;

(b) The total amount of all income benefits paid or awarded the employee under such other worker's compensation law shall be credited against the total amount of income benefits which would have been due the employee under this act, had the claim been made solely under this act;

(c) The total amount of death benefits paid or awarded under such other worker's compensation law shall be credited against the total amount of death benefits due under this act.

(3) "Workers' compensation law" includes "occupational disease law".

(4) Notwithstanding the above, an employee may elect as his exclusive state workers' compensation remedy the provisions of Louisiana's workers' compensation law provided all the following items occur:

(a) This election is clearly stated in a written employment contract signed by the employee prior to the occurrence of an accident or occupational disease as defined in this Chapter.

(b) Louisiana's workers' compensation law has jurisdiction over the accident or occupational disease under its conflict of laws or extraterritorial law.

(c) The employee was domiciled in the state of Louisiana at the time of the accident or the injurious exposure to conditions causing an occupational disease.

Added by Acts 1975, No. 583, §4, eff. Sept. 1, 1975. Acts 1983, 1st Ex. Sess., No. 1, §6; Acts 2001, No. 1014, §1, eff. June 27, 2001.

R.S. 23:1035.2

§1035.2. Claims covered by certain federal laws

No compensation shall be payable in respect to the disability or death of any employee covered by the Federal Employer's Liability Act, the Longshoremen's and Harbor Worker's Compensation Act, or any of its extensions, or the Jones Act.

R.S. 23:1036

§1036. Volunteer firefighters

A. It is hereby declared by the Legislature of Louisiana that the fire prevention and suppression services provided by volunteer fire companies are vital to the protection of the safety of the citizens of the state. This Section is intended to present the state fire marshal with a means by which he shall provide workers' compensation coverage to volunteer members of fire companies. The remedies provided herein shall constitute the exclusive remedy of the volunteer member against the fire company as provided in R.S. 23:1032.

B. The provisions of this Chapter shall apply to claims brought under this Section to the extent that such provisions do not conflict with this Section.

C.(1) The state fire marshal shall obtain workers' compensation insurance for volunteer members, as defined herein, who participate in the normal functions of the fire company. Nothing shall prohibit the state fire marshal from obtaining an insurance policy to provide coverage for a single fire company or multiple fire companies.

(2) A person covered under this Subsection is entitled to medical benefits pursuant to R.S. 23:1203, which benefits shall not be subject to a copayment, deductible, or any other method to shift the cost of compensable medical care to the injured volunteer member.

(3) Any member who is not carried on the membership list of the organization as of the date of the member's injury shall not be entitled to the benefits of this Section.

(4) The fire chief shall by written affidavit attest to the fact that the injury to the volunteer member occurred while the volunteer member was in the line of duty.

D. As used in this Section, unless the context clearly indicates otherwise, the following terms shall be given the meaning ascribed to them in this Subsection:

(1) "Fire company" means any organization established to provide fire prevention and suppression services for the general public.

(2) "Normal functions" means any response to, participation in, or departure from an incident scene, training, meetings, performance of equipment maintenance, or participation in organization functions as authorized by the chief of the fire company.

(3) Repealed by Acts 2009, No. 304, §3, July 1, 2009.

(4) "Volunteer members" means individuals who are carried on the membership list of the organization as active participants in the normal functions of the organization and who receive nominal or no remuneration for their services.

E. Medical benefits payable under this Section shall be paid within sixty days after the fire company, its insurer, or third-party administrator receives written notice thereof. If the volunteer member or his representative knows or reasonably should know that the fire company's coverage is administered or underwritten by an insurance carrier or third-party administrator, then the sixty-day payment period begins when written notice is received by the carrier or third-party administrator.

F, G. Repealed by Acts 2009, No. 304, §3, eff. July 1, 2009.

H. For injury causing death within two years after the last treatment resulting from the accident, there shall be paid reasonable expenses of burial of the volunteer member, not to exceed seven thousand five hundred dollars.

I. In addition to all other defenses available under other provisions of the Louisiana Workers' Compensation Act, a fire company may assert any of the following as defenses to a claim for benefits under this Section:

(1) The presumption under R.S. 33:2581 relating to the development of heart and lung disease during fire service shall not be available to volunteer members claiming benefits under this Section.

(2) No fire company or its insurer shall be liable for benefits under this Section for injuries occurring within the course of, or arising out of, the volunteer member's other employment.

(3) No benefits shall be payable under this Section for a volunteer member's injury during his participation in a parade or other activity unless his participation is authorized by the chief of the fire company.

J. Repealed by Acts 2009, No. 304, §3, eff. July 1, 2009.

K. Any written notice contemplated or required to be made to warrant any award of attorney fees or penalties must be received by the insurance carrier or third party administrator for the fire company when the volunteer member knows or reasonably should know that the coverage provided by the fire company under this Section is administered or underwritten by a carrier or third party administrator, notwithstanding any other provision of law.

L. A fire company shall provide upon request and within a reasonable time period documents, materials, or other information to the state fire marshal in order to effectuate the provisions of this Section.

Acts 1997, No. 1047, §1, eff. July 11, 1997; Acts 1999, No. 234, §1, eff. June 11, 1999; Acts 2009, No. 304, §§2, 3, eff. July 1, 2009.

R.S. 23:1037

§1037. Employees of railroads in interstate or foreign commerce; vessels in interstate or foreign commerce

This Chapter shall not apply to any employer acting as a common carrier while engaged in interstate or foreign commerce by railroad, where the employee of such common carrier was injured or killed while so employed; but if the injury or death of an employee

of a railroad occurs while the employer and employee are both engaged and employed at the time in an intrastate operation or movement not controlled or governed by the laws, rule of liability, or method of compensation which has been or may be established by the Congress of the United States, then this Chapter shall govern and compensation shall be recovered hereunder; but nothing in this Chapter shall be construed to apply to any work done on, nor shall any compensation be payable to the master, officers or members of the crew of, any vessel used in interstate or foreign commerce not registered or enrolled in the State of Louisiana.

R.S. 23:1044

§1044. Presumption of employee status

A person rendering service for another in any trades, businesses or occupations covered by this Chapter is presumed to be an employee under this Chapter.

Every executive officer elected or appointed and empowered in accordance with the charter and by-laws of a corporation, other than a charitable, religious, educational or other non-profit corporation or an official of the state or other political subdivision thereof or of any incorporated public board or commission, shall be an employee of such corporation under this Chapter.

R.S. 23:1045

§1045. Persons exempt from coverage

A.(1) This Chapter shall not apply to, and there is specific exclusion from the operation thereof for, all members of the crew of any airplane engaged in dusting or spraying operations insofar as such members of an airplane crew might be regarded as independent contractors, subcontractors, or employees of any person, firm, or corporation engaged in the principal business of agriculture or farming operations.

(2) All rights of employers and employees in tort are reserved to the parties.

B.(1) The provisions of Subsection A of this Section shall not exempt or in any way apply to independent contractors, subcontractors, or employees of any person, firm, partnership, or corporation engaged in the business of applying any products by use of aircraft, either fixed wing or rotor craft, in connection with commercial agricultural, aquacultural, horticultural, silvicultural, floricultural, or agronomic operations or vegetation suppression.

(2) The provisions of this Subsection shall apply to all independent contractors, subcontractors, and employees of such businesses irrespective of whether such person would be considered a member of the crew of such aircraft.

R.S. 23:1046

§1046. Chapter inapplicable to uncompensated officers and uncompensated members of the board of directors of certain nonprofit organizations

The provisions of this Chapter are inapplicable to uncompensated officers and uncompensated members of the board of directors of bona fide, nonprofit veterans and other bona fide, nonprofit organizations which are charitable, educational, religious, social, civic or fraternal in nature including, but not limited to, the Young Men's Christian Association, the Young Women's Christian Association and all scouting associations of the United States.

R.S. 23:1047

§1047. Real estate salesmen exempt from coverage

A. This Chapter shall not apply to and there is specifically excluded from the operation thereof, any real estate broker or salesman licensed to do business in the state of Louisiana and operating under the auspices of a licensed broker in the state of Louisiana and is working in the course and scope of his real estate business.

B. All rights of employers and employees in tort are reserved to the parties.

R.S. 23:1048

§1048. Landmen exempt from coverage

A. This Chapter shall not apply to, and there is specifically excluded from the operation thereof, any landman rendering services, under the circumstances described in R.S. 23:1472(12)(H)(XIX), that is operating under the auspices of an independent or lead broker landman in the state of Louisiana and who is engaged primarily in negotiations for the acquisition or divestiture of mineral rights, or negotiating business agreements that provide for the exploration for or development of minerals.

B. All rights of employers and employees in tort are reserved to the parties.

WC Liability of Principal Contractors

§1061. Principal contractors; liability

A.(1) Subject to the provisions of Paragraphs (2) and (3) of this Subsection, when any "principal" as defined in R.S. 23:1032(A)(2), undertakes to execute any work, which is a part of his trade, business, or occupation and contracts with any person, in this Section referred to as the "contractor", for the execution by or under the contractor of the whole or any part of the work undertaken by the principal, the principal, as a statutory employer, shall be granted the exclusive remedy protections of R.S. 23:1032 and shall be liable to pay to any employee employed in the execution of the work or to his dependent, any compensation under this Chapter which he would have been liable to pay if the employee had been immediately employed by him; and where compensation is claimed from, or proceedings are taken against, the principal, then, in the application of this Chapter reference to the principal shall be substituted for reference to the employer, except that the amount of compensation shall be calculated with reference to the earnings of the employee under the employer by whom he is immediately employed. For purposes of this Section, work shall be considered part of the principal's trade, business, or occupation if it is an integral part of or essential to the ability of the principal to generate that individual principal's goods, products, or services.

(2) A statutory employer relationship shall exist whenever the services or work provided by the immediate employer is contemplated by or included in a contract between the principal and any person or entity other than the employee's immediate employer.

(3) Except in those instances covered by Paragraph (2) of this Subsection, a statutory employer relationship shall not exist between the principal and the contractor's employees, whether they are direct employees or statutory employees, unless there is a written contract between the principal and a contractor which is the employee's immediate employer or his statutory employer, which recognizes the principal as a statutory employer. When the contract recognizes a statutory employer relationship, there shall be a rebuttable presumption of a statutory employer relationship between the principal and the contractor's employees, whether direct or statutory employees. This presumption may be overcome only by showing that the work is not an integral part of or essential to the ability of the principal to generate that individual principal's goods, products, or services.

B. When the principal is liable to pay compensation under this Section, he shall be entitled to indemnity from any person who independently of this Section would have been liable to pay compensation to the employee or his dependent, and shall have a cause of action therefor.

Exclusive Remedy

§1032. Exclusiveness of rights and remedies; employer's liability to prosecution under other laws

A.(1)(a) Except for intentional acts provided for in Subsection B, the rights and remedies herein granted to an employee or his dependent on account of an injury, or compensable sickness or disease for which he is entitled to compensation under this Chapter, shall be exclusive of all other rights, remedies, and claims for damages, including but not limited to punitive or exemplary damages, unless such rights, remedies, and damages are created by a statute, whether now existing or created in the future, expressly establishing same as available to such employee, his personal representatives, dependents, or relations, as against his employer, or any principal or any officer, director, stockholder, partner, or employee of such employer or principal, for said injury, or compensable sickness or disease.

(b) This exclusive remedy is exclusive of all claims, including any claims that might arise against his employer, or any principal or any officer, director, stockholder, partner, or employee of such employer or principal under any dual capacity theory or doctrine.

(2) For purposes of this Section, the word "principal" shall be defined as any person who undertakes to execute any work which is a part of his trade, business, or occupation in which he was engaged at the time of the injury, or which he had contracted to perform and contracts with any person for the execution thereof.

B. Nothing in this Chapter shall affect the liability of the employer, or any officer, director, stockholder, partner, or employee of such employer or principal to a fine or penalty under any other statute or the liability, civil or criminal, resulting from an intentional act.

C. The immunity from civil liability provided by this Section shall not extend to:

(1) Any officer, director, stockholder, partner, or employee of such employer or principal who is not engaged at the time of the injury in the normal course and scope of his employment; and

(2) To the liability of any partner in a partnership which has been formed for the purpose of evading any of the provisions of this Section.

Agent GSIF Insolvency Limitation

§1198. Licensing of agents; claims against insurance agents

A. Any person soliciting membership for a fund shall be licensed by the department as a property and casualty agent. No employees of a bona fide trade or professional association which has established a fund or employees of a fund shall be required to be so licensed if the solicitation of membership for the fund is not the primary duty of the employees.

B. No action shall lie against an insurance agent, insurance broker, or other person involved in the marketing, selling, or solicitation of participation in funds authorized by this Subpart for any claims arising out of the insolvency of any fund or the inability of a fund to pay claims as the claims become due unless and until any claimant shall have first exhausted all remedies available to him against the members of the fund as provided by R.S. 23:1196.

Surplus Lines Authorization

§432. Surplus lines insurance from unauthorized insurers

Surplus lines insurance, as defined in R.S. 22:46(17), may be procured from approved unauthorized insurers or eligible unauthorized insurers, provided that the insurance is as defined in R.S. 22:46(2) and (7.1) and sometimes referred to in this Title as "surplus lines insurers". It shall be procured through licensed surplus lines brokers and may be procured without regard to the availability of coverage from authorized insurers.

§433. Endorsement of contract

A. Each insurance policy or contract procured and delivered as surplus lines coverage pursuant to this Subpart shall have the following notice:

NOTICE

This insurance policy is delivered as surplus lines coverage under the Louisiana Insurance Code.

In the event of insolvency of the company issuing this contract, the policyholder or claimant is not covered by the Louisiana Insurance Guaranty Association which guarantees only specific types of policies issued by insurance companies authorized to do business in Louisiana.

This surplus lines policy has been procured by the following licensed Louisiana surplus lines broker:

Signature of Licensed Louisiana Surplus Lines Broker

or Authorized Representative

Printed Name of Licensed Louisiana Surplus Lines Broker

B. The notice required pursuant to Subsection A of this Section shall be:

(1) Prominently displayed in the color red or prominently offset by a black border.

(2) Printed or stamped on the policy or contract in bold and in not less than ten-point type.

(3) Signed by the surplus lines broker who procured the policy or contract.

§434. Surplus lines insurance valid

Insurance contracts procured as surplus lines coverage from approved unauthorized insurers in accordance with this Subpart 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 authorized insurers.

Surplus Lines Solvency Requirements

§435. Solvency and eligibility requirements

A. A surplus lines broker shall place surplus lines insurance only with surplus lines insurers that are:

(1) Financially sound.

(2) Authorized in their domiciliary jurisdictions to write the type of insurance placed.

B. A surplus lines broker shall not place coverage with a surplus lines insurer, unless, at the time of placement, the surplus lines broker has determined that the surplus lines insurer qualifies under one of the following Paragraphs:

(1)(a) If it is a foreign insurer that it has capital and surplus or its equivalent under the laws of its domiciliary jurisdiction which equals the greater of:

(i) The minimum capital and surplus requirements under the laws of this state.

(ii) Fifteen million dollars.

(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 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 commissioner make an affirmative finding of acceptability when an unauthorized insurer's capital and surplus is less than four million five hundred thousand dollars.

(2)(a) If it is an alien insurer, it shall be listed by the International Insurers Department of the National Association of Insurance Commissioners on its Quarterly Listing of Alien Insurers.

(b) The commissioner may waive the requirement in Subparagraph (a) of this Paragraph upon an affirmative finding of the insurer's meeting the requirements for capital and surplus or acceptability pursuant to Paragraph (1) of this Subsection.

C. In addition to any other statements or reports required by this Subpart, the commissioner of insurance may request from any surplus lines broker full and complete information respecting the financial stability, reputation, and integrity of any unauthorized insurer with whom any such surplus lines broker has dealt, or proposes to deal, in the transaction of insurance business. The surplus lines broker shall promptly furnish in written or printed form so much of the information requested as he can produce.

Surplus Lines “White List”

§436. Approved unauthorized insurers; list; requirements; removal

A. The commissioner of insurance shall maintain a list of approved unauthorized insurers from those eligible unauthorized insurers that apply for approval and satisfy the criteria established by the commissioner. Placement on the list of approved unauthorized insurers shall be prima facie evidence that an unauthorized insurer meets the financial and eligibility criteria of R.S. 22:435(A) and (B).

B. To obtain and maintain placement on the list of approved unauthorized insurers, an unauthorized insurer shall comply with the provisions of R.S. 22:435 applicable to foreign or alien insurers, respectively, and shall annually file with the commissioner the following, unless available to the commissioner through the NAIC or from public sources:

(1) A copy of the insurer's annual statement as of the preceding December thirty-first, evidencing that the insurer has complied with the provisions of R.S. 22:435.

(2) Evidence that, if the insurer issues workers' compensation insurance in this state, it has established and maintained a workers' compensation claims office pursuant to R.S. 23:1161.1 or has retained a licensed claims adjuster.

(3) A copy of the producer production report in a form required by the commissioner listing all business placed with the company by licensed surplus lines brokers. The report shall be filed with the commissioner no later than April fifteenth of each year.

C. The commissioner may remove an approved unauthorized insurer from the list if:

(1) The insurer fails to pay any required fee.

(2) The insurer fails to deliver any information requested by the commissioner within thirty days.

(3) The insurer issues workers' compensation insurance within the state, and fails to establish and maintain a workers' compensation claims office pursuant to R.S. 23:1161.1 or fails to retain a licensed claims adjuster.

(4) The insurer is in unsound financial condition or has acted in an untrustworthy manner.

(5) The insurer no longer satisfies the requirements set forth in R.S. 22:435.

(6) The insurer has willfully violated the laws of this state.

(7) The insurer conducts improper claims practices, including but not limited to unfair trade practices as defined in Part IV of Chapter 7 of this Title, R.S. 22:1961 et seq.

D. Upon removing an insurer from the list of approved unauthorized insurers, the commissioner shall notify the insurer and all licensed surplus lines brokers of such action in writing. Such notice to licensed surplus lines brokers may, at the option of the surplus lines broker, be sent by the commissioner via electronic mail.

E. The commissioner shall have the authority to adopt and promulgate such rules and regulations as are necessary to carry out the provisions of this Section in accordance with the Administrative Procedure Act.

§437. Records of surplus lines broker

A. Each licensed surplus lines broker shall keep a full and true record of each surplus line contract, procured by him including a copy of the daily report, if any, showing such of the following items as may be applicable:

(1) Amount of the insurance.
(2) Gross premiums charged.
(3) Return premium paid, if any.
(4) Rate of premium charged upon the several items of property.
(5) Effective date of the contract, and the terms thereof.
(6) Name and address of the insurer.
(7) Name and address of the insured.
(8) Brief general description of property insured and where located.
(9) Other information as may be required by the commissioner of insurance, including but not limited to the address of the worker's compensation claims office established by the insurer pursuant to R.S. 23:1161.1 and the name and address of the person authorized by the insurer to settle worker's compensation claims through such office or of the licensed claims adjuster retained by the insurer.

B. The record shall at all times be open to examination by the commissioner of insurance and whenever an examination shall be made by him of a surplus lines broker, such examination shall be in compliance with and pursuant to the provisions of Chapter 8 of this Title, R.S. 22:1981 et seq., insofar as the provisions of that Chapter are applicable to such examination.

Surplus Lines Acknowledgement Form

§438. Acknowledgment of applicant for insurance

A. Any licensed surplus lines broker that procures a personal lines policy with an approved unauthorized insurer or eligible unauthorized insurer shall obtain from the applicant for insurance no later than the date of binding coverage, an acknowledgment on a standardized form promulgated by the commissioner of insurance which shall be maintained by the licensed surplus lines broker. The acknowledgment shall verify that:

(1) The applicant for insurance was expressly advised prior to placement of the surplus lines insurance.

(2) The insurance may be placed with an approved unauthorized insurer or eligible unauthorized insurer.

(3) In the event of insolvency of the insurer, losses shall not be paid by the Louisiana Insurance Guaranty Association.

(4) The applicant for insurance expressly authorizes the procurement of surplus lines insurance coverage.

(5) The coverage is being procured through a duly licensed surplus lines broker.

B. As long as the personal lines policy continues to be renewed by the same approved unauthorized insurer or eligible unauthorized insurer, there shall not be a need for new acknowledgments at each renewal. At renewal, if the personal lines policy is placed with a different approved unauthorized insurer or eligible unauthorized insurer, then a new acknowledgment shall be obtained in the manner outlined in Subsection A of this Section.

Surplus Lines Tax

§439. Tax on surplus lines

A.(1) On or before March first, June first, September first, and December first of each year, each surplus lines broker shall transmit to the commissioner of insurance a surplus lines tax report for the prior calendar quarter for single-state, Louisiana properties, risks, or exposures. This report shall be in a manner and format prescribed by the commissioner of insurance and include any additional information as required by the commissioner. The reporting of transactions shall be as follows:

(a) All new and renewal policies will be included in the report for the calendar quarter in which the effective date of the policy falls.

(b) All other premium transactions will be included in the report for the calendar quarter in which the invoice falls.

(2) Along with the report required to be filed on the due dates provided in Paragraph (1) of this Subsection, each surplus lines broker shall remit to the commissioner of insurance a tax on the premiums on surplus lines insurance reported in the quarterly surplus lines tax report, at the rate of five percent per annum. Such tax when collected by the commissioner of insurance shall be paid to the state treasurer and be credited to the general fund.

B. Every person placing insurance for single-state, Louisiana properties, risks, or exposures with an unauthorized insurer without going through a licensed Louisiana producer or surplus lines broker, except as provided in R.S. 22:432, shall remit to the commissioner of insurance a tax of five percent of the gross premium, such tax to be paid at the same time and under the same conditions as that levied on surplus lines brokers under the provisions of Subsection A of this Section. Such tax when collected by the commissioner of insurance shall be paid to the state treasurer and be credited to the general fund.

C. There shall be a tax on all premiums paid for surplus lines insurance covering properties, risks, or exposures for more than one state and for which Louisiana is the home state of the insured. Surplus lines brokers and independently procuring insureds shall remit the tax to the commissioner who shall transfer it to the general fund less the amount due to other states pursuant to Subsection D of this Section. The state shall return to the insured, through the surplus lines broker, if any, the tax on any portion of the premium unearned at the termination of the insurance. The surplus lines licensee or broker shall not rebate, for any reason, any part of the tax.

D. The tax required in Subsection C of this Section shall be on the gross premiums charged for any surplus lines insurance policy covering properties, risks, or exposures in more than one state and for which Louisiana is the home state of the insured. The

surplus lines broker or independently procuring insured shall compute the sum payable based upon all of the following:

(1) An amount equal to five percent on that portion of the gross premiums allocated to this state.

(2) Plus an amount equal to the portion of the premiums allocated to other states or territories on the basis of the tax rates and fees applicable to properties, risks, or exposures located or to be performed in other states and territories that participate in a reciprocal allocation procedure as authorized herein.

(3) Less the amount of gross premiums allocated to this state and returned to the insured.

(4) Less the net premium tax collected on properties, risks, or exposures allocable to states or territories that do not participate in a reciprocal allocation procedure with this state.

E. Each surplus lines broker and insured independently procuring surplus lines insurance covering properties, risks, or exposures in more than one state for which Louisiana is the home state of the insured shall transmit to the commissioner of insurance a surplus lines tax report for the prior calendar quarter not later than on the dates designated by the commissioner. The commissioner shall prescribe the form and content of the report, which shall conform to any interstate agreement or compact for the receipt, allocation, and distribution of surplus lines premium taxes.

F. The home state of the insured for purposes of this Section shall be as defined in R.S. 22:46(8.1).

G.(1) The commissioner shall on behalf of the state of Louisiana enter into the Nonadmitted Insurance Multi-State Agreement or other cooperative compacts or agreements with other states for any of the following:

(a) The receipt, allocation, and disbursement among the participating, compacting, or contracting states of premium taxes attributable to the placement of surplus lines insurance.

(b) A uniform method of allocating and reporting among surplus lines insurance risk classifications.

(c) Sharing information among states relating to surplus lines insurance premium taxes.

(d) Such other purposes that are necessary and proper to maintain the state's revenues from surplus lines insurance premium taxes and to comply with the Nonadmitted and Reinsurance Reform Act of 2010 (15 U.S.C. 8206, et seq.).

(2) Such compact or agreement shall be in writing and filed with the commissioner prior to its taking effect.

(3) Such compact or agreement may provide for any of the following:

(a) The use of a clearinghouse to perform functions required under the agreement.

(b) The use of an allocation schedule to allocate risk and compute the tax due on the portion of premium attributable to each risk classification and to each state where properties, risks, or exposures are located.

(c) Any other provisions that will facilitate the administration of the compact or agreement.

(4) The commissioner may, as required by the terms of the compact or agreement, forward to officers of another state or to an agreed clearinghouse any information in the commissioner's possession relative to nonadmitted insurance.

(5) The commissioner may promulgate rules and regulations for the administration and enforcement of any such compact or agreement, including the assessment of a clearinghouse transaction fee.

H. The tax imposed on surplus lines pursuant to this Section shall not apply to the purchase of excess insurance obtained by an interlocal risk management agency pursuant to R.S. 33:1359 or 1485.

How To Find Louisiana Statutes

Louisiana statutes may be found on the Louisiana State Legislature website:

http://www.legis.la.gov/Legis/Home.aspx

Click on the “Laws” button in the upper left hand corner of the menu bar.

You can view a current copy of a specific statute by entering the title number and section number. The Insurance Code is Title 22.

You can also search the statutes for key words. Most statutes of interest to IIABL member agents would be found in Louisiana Revised Statutes. Simply click the “Revised Statutes” box and then type in key words for the type of statute you are trying to find. You may have to try different search terms to find the correct statute.